

# Abstracts

## Poster abstracts

### P1 GENDER MATTERS WHEN CONSIDERING VACCINATION AGAINST HEPATITIS B

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**Background:** Different rapid vaccination schedules for hepatitis B have previously been accepted as equally efficacious. This study was designed to compare vaccinations schedules at 0, 7, and 21 days (schedule-A) and 0, 1, 2 months (schedule-B) for completion of three vaccinations and the development of adequate immunity—that is, anti-HBs >10 IU/l eight weeks after the third vaccine.

**Method:** A retrospective analysis of 428 patient records. Patients with immunodeficiency were excluded from analysis.

**Results:** See table. Male patients were equally matched for indication for vaccination between the two schedules. Female patients who had been sexually assaulted were of higher proportion in schedule-A, with a higher proportion of sex industry workers in schedule-B.

**Conclusion:** This study shows that females are much more likely to complete vaccination schedule-A than schedule-B, however they appear to be equally efficacious. Males in comparison are equally likely to complete either vaccination schedule, but show a significantly lower likelihood of developing adequate anti-HBs titre levels. The routine use of hepatitis B vaccination schedule 0, 7, 21 days for males should be reconsidered.

#### Abstract P1

	Schedule-A	Schedule-B	Outcome
Male (median age 22)	154	128	
Completion rate	70%	68%	Non-significant p<0.05
Anti HBs>10 IU/l	52%	79%	
Female (median age 21)	94	54	
Completion rate	74%	46%	p<0.03 Non-significant
Anti HBs>10 IU/l	86%	85%	

### P2 SERVICE IMPLICATIONS OF CHANGES TO HEPATITIS B VACCINATION GUIDELINES

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**Background:** The new draft guidelines for hepatitis B vaccination give much lower antibody levels for successful immunisation. We have reviewed anti-HBs tests over the past year to ascertain the number of repeat vaccinations that could have been avoided by the new draft criteria.

**Methods:** Over the past year (Jan–Dec 2005) we performed 127 tests on 105 individuals. Data were collected on the first test if more than one test was performed. The commonest reason for testing was a history of vaccination (65 patients), 22 patients had antibody checks following full courses of vaccination, while seven were follow ups after boosters.

**Results:** Of the 94 tests for which we have complete information, 37 had antibody levels over 100 iu/ml, while 17 had antibody levels between 10 and 100 iu/ml. The latter cases (16% of those tested) would not require further boosters according to the new criteria. In individuals

being tested after a full course of immunisation, or after booster, only one of 29 had intermediate antibody levels, 15 had levels greater than 100 iu/ml, and there were 13 non-responders. The majority of cases where antibody levels were less than 10 iu/ml were in people giving a history of immunisation (27 of 37) and it is likely that many of these were mistaken about their vaccination status.

**Conclusion:** Uptake of the new guidelines could avoid a significant number of patients being recalled for boosters.

### P3 HETEROSEXUAL SYPHILIS IN SOUTH LONDON: HOW CAN WE ENHANCE SURVEILLANCE?

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**Background:** The resurgence of syphilis in London has predominantly been associated with gay men. In response, the HPA started Enhanced Syphilis Surveillance (ESS) in 2001. A heterosexual outbreak in 2002, linked with commercial sex workers in South London, prompted Local Enhanced Syphilis Surveillance (LESS) aiming to better understand the epidemic dynamics and inform interventions. We undertook an evaluation of the usefulness and completeness of these surveillance systems.

**Methods:** Three interrelated but independent surveillance sources (KC60, ESS, and LESS) were analysed from July 2002 to the end of 2004 for all 10 South London GUM clinics. Only cases of heterosexual infectious syphilis (primary, secondary, and early latent syphilis) were included in this analysis.

**Results:** The KC60 returns describe 714 (100%) cases of infectious syphilis from all clinics over this period. In the same location and time period, 245 (34%) were reported from six clinics via ESS and 215 (30%) cases from five participating clinics using LESS. Within the two enhanced datasets, using clinic numbers and date of birth, 168 (24%) patients were in both datasets while 83 (12%) and 53 (7%) were only in the ESS and LESS respectively. The proportion of KC60 returns with concomitant enhanced surveillance ranged from 0 to 90% across the 10 clinics.

**Conclusion:** Existing enhanced syphilis surveillance datasets only measure a fraction of KC60 reported cases of infectious heterosexual syphilis in South London. Validation is planned by visiting clinics. The voluntary reporting strategy of the national ESS does not appear to accurately describe this resurgent epidemic.

### P4 CONGENITAL SYPHILIS: THE NEED FOR IMPROVED SURVEILLANCE

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**Background:** Between 2000 and 2004, diagnoses of infectious syphilis rose by 583% (134 to 915) in heterosexual men and 255% (78 to 277) in women. As incidence has risen cases of congenital syphilis have emerged, including two case reports. However, there is no systematic national surveillance of congenital syphilis based on agreed case definitions.

**Methods:** Review of routine surveillance of congenital syphilis from KC60 returns and Hospital Episode Statistics (inpatients) between 1996 and 2004.

**Results:** Trends in cases of congenital syphilis are shown in the following table. No standard case definition was used and it is unknown whether the mothers attended antenatal screening in the UK.

#### Abstract P4

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Syphilis <2 years (KC60 A7)	2	1	2	2	9	2	7	3	6
Syphilis 0–4 years (HES)	1	3	6	4	NA	NA	NA	NA	NA

**Discussion:** Congenital syphilis is a preventable disease and its re-emergence in the UK reflects a failure of prenatal care delivery systems and syphilis control programmes. Anecdotal reports suggest that many more cases have been seen than reported. To estimate the burden of cases of congenital syphilis and maternal syphilis it is proposed that a new surveillance system should be instigated. This would require agreement on laboratory and clinical case definitions, and include reference laboratories, specialists in genitourinary medicine, paediatrics, and obstetrics and gynaecology. The detailed plan for this new surveillance initiative will be presented.

#### **P5 DON'T FORGET SYPHILIS! NEUROLOGICAL PRESENTATIONS OF SECONDARY SYPHILIS**

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**Introduction:** Increases in the incidence of infectious syphilis have been reported nationally in recent years. This has resulted in an increase in presentations to non-GUM medical specialities.

**Case 1:** A 50 year old man was referred to dermatology with a two week history of an extensive macular rash. He subsequently developed bilateral sensori-neural deafness and left visual loss due to vitritis. Syphilis serology was positive (RPR 64). He was referred to Neurology. He had recently returned from working in central Africa. He denied any sexual contacts other than his wife (whose syphilis serology was negative). He was treated with 17 day course of procaine penicillin, probenecid, and steroids. On completion of treatment his hearing and vision had significantly improved. He was HIV negative.

**Case 2:** A 72 year old man attended neurology outpatients following a fall and reduced mobility. Examination showed reduced lower limb sensation, vibration sense, and a high stepping gait. Ankle jerks were absent. There was marked left optic disc swelling and a widespread maculopapular rash. Syphilis serology was positive (RPR 128). He admitted to sexual contact with a male partner four months previously. He was treated as an inpatient with 17 days procaine penicillin, probenecid, and steroids. At discharge the optic disc swelling and mobility improved considerably. HIV testing was declined.

**Discussion:** Non-genitourinary specialists need to be made aware of the changing epidemiology of syphilis and its protean presentations.

#### **P6 SUDDEN VISUAL LOSS AS A PRESENTING MANIFESTATION OF SYPHILIS**

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A 46 year old male presented in March 2005 with sudden onset of visual loss with floaters in the left eye. On initial visit he had extensive investigation including MRI, perimetry, and ultrasonography of eye, but no identifiable cause was found. Visual perimetry showed visual loss centrally and inferiorly in the left eye. Ultrasonography showed bilateral disc elevation with no fluid distention of optic sheaths. He had HIV serology done at this stage in addition to other blood tests, but not syphilis serology. He was seronegative for HIV infection. Meanwhile he had spontaneous recovery of vision without any treatment. In October 2005, nearly six months later, he had syphilis serology done and the cause was identified. He had VDRL reactivity of 1:64 and positive treponemal and IgM test. His CSF VDRL was reactive 1:2 and positive treponemal test. His CSF protein was 0.54 and glucose -3.3 (serum -4.6). He was treated with neuro syphilis regimen of penicillin and had good serological response with decrease in VDRL titres. He has had no further visual problems.

With the recent outbreak in syphilis there is resurgence in ocular syphilis with series reported from Manchester. As in our patient, at many instances syphilis as a cause of visual problem was not considered and there was delay in diagnosis. As there are instances of permanent visual loss due to ocular syphilis, in anyone with atypical or unexplained cause of visual problems syphilis should be considered in differential diagnosis and excluded.

#### **P7 HIV INFECTION IS A RISK FACTOR FOR GONORRHOEA**

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**Aim:** To describe changes identified between two consecutive audits of gonorrhoea (GC) infection in three inner city genitourinary medicine clinics.

**Methods:** Comparison of the data from two retrospective case note audits, the first in 2003 and the second 2004-05.

**Results:** The number of GC diagnoses rose over the study period; 208 v 274; 2003 v 2004-05. A consistently high proportion of men diagnosed with GC are men who have sex with men; 65.7% v 69.8%; 2003 v 2004-05 ( $p=0.357$ ). Chlamydia co-infection rates remain static and are comparable with national figures; 12.1% v 12.9%; 2003 v 2004-05 ( $p=0.804$ ). However, there is a significant increase in the rates of GC diagnoses in known HIV infected individuals; 19.2% v 29.4%; 2003 v 2004-05 ( $p=0.013$ ).

**Conclusion:** Our data reflect constant GC infection in contrast to recent Health Protection Agency reports of a decline. Of particular concern is the increased incidence of GC diagnoses in HIV positive individuals suggesting ongoing high risk behaviour.

#### **P8 DRAMATIC FALL IN DIAGNOSED GONORRHOEA IN NORTH WEST LONDON 2000-04. WHY HAS THIS HAPPENED?**

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**Objectives:** To compare the patients diagnosed with gonorrhoea in the second half of 2000 and 2004 to identify the scale of the fall in diagnosed gonorrhoea and identify any significant contributing factors.

**Methods:** All patients in these two periods were identified and their case notes examined for demographic, risk, and co-infection data.

**Results:** From 2000 to 2005 there has been a 60% fall in annually diagnosed gonorrhoea (from 443 to 173 cases) in this clinic. Comparing the second halves of 2000 and 2004 in more detail, the fall in diagnosed gonorrhoea was 46% from 232 to 127 cases. The falls were largest in men 16-19 years old (21 to 8 cases, 62% fall) and women 20-24 years old (23 to 10 cases, 55%) and least in women 16-19 years old (23 to 21 cases, 9% fall) although none was statistically significant. There were no changes in other demographic, risk, or co-infection rates in these patients. Over the same periods we saw 10% more new patients in this clinic with no significant fall in rates of any other diagnosed STI.

**Conclusion:** In the last five years there has been a dramatic fall in diagnosed gonorrhoea in this part of London which is much larger than the decrease seen nationally. This cannot be explained by altered access to care or detectable changing population patterns but seems to be a true and sustained fall.

#### **P9 TARGETING INTERVENTIONS FOR GONORRHOEA: DO GENITOURINARY CLINICS ATTRACT ALL THE APPROPRIATE CLIENTS?**

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**Background:** The rate of gonorrhoea varies by age, gender, and ethnic group. The aim of this study was to investigate whether an inner city GUM clinic caters to the needs of all the groups at risk of gonorrhoea.

**Methods:** Cross sectional analysis of all cases of heterosexually acquired gonorrhoea attending an inner city GUM clinic in 2005.

**Results:** Of the 7018 males seen in the department, 516 (7%) had gonorrhoea. 8845 females were seen, of whom 180 (2%) had gonorrhoea. The majority of male cases (83%) attended due to having symptoms of gonorrhoea. Women were five times more likely than men to attend as a contact of gonorrhoea. Although black Caribbean and black British clients accounted for 65% of the cases of gonorrhoea seen in the department, white clients attending the department had an equivalent risk of having gonorrhoea as black Caribbeans. Black Africans had a RR of 0.2 (CI 0.1 to 0.8) of having gonorrhoea. Numbers of contacts were equivalent in all ethnic groups. More than 90% of clients fail to provide evidence of all their recent contacts being screened for gonorrhoea.

**Conclusions:** The clinic attracts those clients at high risk of gonorrhoea, regardless of ethnic group. More than half of female contacts do not access the clinic, possibly due to male index cases failing to notify all their partners of the need for treatment. There is a need for community screening and treatment for gonorrhoea to target those clients who do not access the GU clinic.

# **P10 COMPARISON OF STRAND DISPLACEMENT AMPLIFICATION ASSAY AND CULTURE FOR NEISSERIA FOR THE DIAGNOSIS OF RECTAL GONOCOCCAL INFECTION IN MEN WHO HAVE SEX WITH MEN**

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**Introduction:** Nucleic acid amplification tests have advantages over culture for diagnosis of some sexually transmitted infections though the specificity of available tests for N gonorrhoeae from genital sites has been suboptimal. With increasing support for routine screening for rectal chlamydia among men who have sex with men (MSM) the availability of a duplex test for both infections looks advantageous.

**Methods:** All MSM presenting to a dedicated after hours gay men's clinic in London were offered rectal chlamydia screening using BDProbeTec strand displacement amplification (SDA) on rectal swab samples taken by clinic staff. As part of the routine sexual health screen rectal swabs were also taken and inoculated onto VCA Neisseria culture plates. The clinical and laboratory features of those who tested positive on either test were compared.

**Results:** Among men who tested positive for rectal gonorrhoea, the concordance rate between the two tests was high. There were several cases that were positive on SDA only and repeat culture, where available, confirmed the infection. An updated analysis of results will be presented.

**Conclusion:** The performance of SDA testing for rectal gonorrhoea was satisfactory and in our cohort false positive SDA results occurred rarely. The test offers the advantage of combined chlamydia and gonorrhoea testing from the same rectal swab sample. This test could be suitable as an initial screening test for rectal gonorrhoea (and chlamydia) in asymptomatic MSM with Neisseria culture being reserved for confirmation of positive SDA samples.

# **P11 RECTAL SWABS FOR GONORRHOEA SCREENING IN FEMALES: IS IT NECESSARY?**

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**Introduction:** The National Guideline on the Diagnosis and Treatment of Gonorrhoea (GC) in Adults 2005 recommends that rectal specimens are collected for diagnosis of GC in women when they are symptomatic at this site, when a sexual partner has GC or when indicated by the sexual history. In our unit, rectal swabs are routinely taken from all women attending for genito-urinary screening. This study was undertaken to scrutinise this practice.

**Method:** We retrospectively analysed the results of all genital, rectal, and oropharyngeal swabs that were taken for the diagnosis of GC from the microbiology database of all women attending the clinic from 01/04/2003 to 31/03/2005. The notes of patients with positive rectal swabs were analysed for partner positivity, symptoms at and remote to the site, and sexual history.

**Results:** 5662 swabs were tested for GC during this period. 120 (2.12%) were positive at any one of the sites. 10/5662 (0.18%) patients had GC isolated from the rectal site only. Partner had already tested positive for GC in 2/10 (20%) patients, one of whom gave history of anal intercourse. 1/10 (10%) patients was symptomatic at the rectal site and 6/10 (60%) complained of urogenital symptoms. Thus, 7/10 (70%) patients were asymptomatic at the rectal site and without a history of anal intercourse or infected partner.

**Conclusion:** We would have missed the diagnosis of GC in 7/120 (5.83%) females if guidelines were strictly followed. Thus exclusion of rectal site for testing could result in misdiagnosis in a small proportion of patients.

# **P12 A REVIEW OF THE MANAGEMENT OF PHARYNGEAL GONORRHOEA**

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**Objectives:** To review the management of pharyngeal gonorrhoea (GC) in view of the recent revision of National guidelines and evolving antibiotic resistance.

**Methods:** A retrospective audit of all diagnoses of pharyngeal gonorrhoea between June 2004 and June 2005. Case notes were reviewed and data collected regarding demographics, sites of infection, co-infection, treatment and timing of test of cure and follow up.

**Results:** There were 51 diagnoses of pharyngeal GC, 22 women and 29 men. Of these patients, 88% were white of UK origin. Twenty eight men were men who have sex with men (MSM). Treatment with oral cefixime was given in 46 (90%) patients. Of these patients 87% had one test of cure (TOC) and 61% had two TOCs. Positive GC results were found in five patients at first TOC and two of these were thought to be re-infection. At second TOC one of these remained positive which was very likely to be re-infection. All five patients with positive TOC received cefixime 400 mg stat initially. However 15 patients in total had received Cefixime 400 mg stat doses, 10 of whom had negative TOC.

**Discussion:** The current BASHH guidelines do not recommend cefixime as treatment for Pharyngeal GC. However cefixime is a relatively trouble-free treatment. We believe the results of this audit suggest the need for further evidence on the management of pharyngeal GC. We would encourage further debate on this issue and plan to conduct a further audit on this topic.

# **P13 MANAGEMENT OF PELVIC INFLAMMATORY DISEASE AT A GENITOURINARY MEDICINE CLINIC IN A TEACHING HOSPITAL**

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**Background:** We audited the management of pelvic inflammatory disease (PID) at the GUM clinic at the Leicester Royal Infirmary. Our department manages the patients with PID according to the National Guidelines for the Management of Pelvic Inflammatory Disease (BASHH).

**Methods:** 101 patients were identified to have PID over 12 months in 2004. Following information was collected: age, contraception used, choice of antibiotics to treat PID, the investigations carried out and partner management.

**Results:** There were 33 (33%) patients in the age group of 20–24 years, and 39 (39%) patients did not use any type of contraception. Chlamydia and gonorrhoea were diagnosed in 18 and one patients respectively, while one patient had both these organisms isolated. 94 (94%) patients had been treated appropriately with a regimen comprising of Ceftriaxone, Doxycycline, or ofloxacin and metronidazole in the recommended dosage. Seven patients received suboptimal therapy. 42 patients were reviewed within 2–6 weeks following treatment, five of whom continued to have persistent symptoms or signs at the time of follow up. There were 23 patients for whom a contact was documented to have been appropriately managed, which is equivalent of 0.23 contacts per case of PID.

**Discussion:** Although most patients with PID were treated appropriately, 6% did not receive appropriate treatment. Further training of staff has been arranged to improve this. The number of contacts treated for every case of PID falls short of meeting national target (0.4 contacts per case of PID) and is a huge challenge for such an important clinical condition.

# **P14 ARE WE MISSING MUMPS EPIDIDYMO-ORCHITIS?**

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**Aim and Methods:** Mumps epididymo-orchitis has not been recorded as a cause of testicular symptoms without systemic features (including parotitis). The aim of the present study was to assess if we were missing cases during a previous outbreak of mumps in the community. During a prospective pilot study from November 2005 to February 2006 all patients presenting with symptoms or signs of epididymo-orchitis were studied. These patients were assessed for previous exposure to mumps virus or vaccine, and any current evidence of systemic illness. All patients included had a full sexual health screen (loop test, Chlamydia PCR, GC culture, HIV, and VDRL/TPPA), UTI excluded by urinalysis and MSSU and mumps serology (IgM and IgG) preformed.

**Results:** At interim analysis (6/1/6) 15 patients met inclusion criteria. Their ages ranged from 18–42, average 30.6. All had symptoms, of these 12 had testicular pain, five swelling, (three had both pain and swelling), three also had dysuria. On examination nine had tenderness, four swelling, (one both tenderness and swelling), and three had no signs. 13 denied history of mumps, none had records of vaccination, three described fever. None had parotid swelling. Three patients were Chlamydia PCR positive, two had Candida cultured, three had NSU (>10 PMNL/high powered field), and seven had negative STI screen



(one known HIV +ve). All had -ve IgM mumps serology, one was IgG +ve.

**Conclusion:** Although the numbers are small there is no evidence of testicular symptoms in absence of systemic illness being caused by mumps in genitourinary clinic.

### P15 IF IT'S NOT LYMPHOGRAULOMA VENEREUM, WHAT ELSE COULD IT BE?

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**Case report:** A 41 year old Ukrainian heterosexual married male presented with a 10 day history of painful left inguinal lymphadenopathy, fever, and macular papular rash over his trunk. He reported casual unprotected sex with a Ukrainian female five months earlier.

Examination revealed three enlarged (4 cm) firm, tender left inguinal lymph nodes with overlying erythema. The differential diagnoses included HIV seroconversion, secondary syphilis, and lymphogranuloma venereum (LGV).

A sexual health screen including urethral *Chlamydia trachomatis* (CT) swab, syphilis, and HIV serologies were negative. His chlamydial serology for L2 serovar was slightly raised. *Bartonella Henselae* titres (causative agent of cat scratch disease, CSD) were markedly raised but polymerase chain reaction from an excised lymph node was negative for *Bartonella*. This did not exclude the diagnosis. Histology showed necrotising granulomas with microabscess formation, suggestive of either CSD or LGV. Repeat serology for both conditions in the convalescent period did not show any significant changes in titres. He was treated with a three week course of doxycycline and on review a month later the lymphadenopathy had completely resolved.

**Conclusion:** CSD should be considered in the differential diagnosis of unilateral inguinal lymphadenopathy, even in the absence of a history of cat exposure as in this case. Serological cross reactivity to CT L2 serovar by *Bartonella* infection can happen, but the reverse is unusual, favouring CSD as the diagnosis in this patient.

### P16 EXPANDED CASE FINDING FOR LYMPHOGRAULOMA VENEREUM IN MEN WHO HAVE SEX WITH MEN PRESENTING TO GENITOURINARY AND HIV SERVICES

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**Background:** Identification of cases of lymphogranuloma venereum (LGV) has been facilitated by increased awareness among clinicians following the Health Protection Agency's (HPA) initiative to improve diagnosis of LGV in men who have sex with men (MSM). Expanded case finding was initiated in May 2005 and our centre is one of two in the UK involved with this.

**Methods:** All MSM presenting to our GU and HIV services for sexual health screening are routinely offered testing for urethral and depending on sexual history, rectal chlamydial infection using real-time DNA amplification. Positive samples are sent to the HPA for identification of LGV associated *Chlamydia trachomatis*.

**Results:** To date, a total of 205 MSM have had STI screening including 30 urethral, four rectal, and 171 urethral and rectal chlamydia samples as of 1/11/2005. Since then 53 (30.3%) cases of rectal chlamydia infection have been identified and of these 11 have been confirmed as LGV. The results of eight chlamydia positive rectal samples are pending further testing at the HPA reference laboratory.

**Conclusion:** Given the increasing incidence of LGV and the presence of asymptomatic infection, we recommend routine screening in high risk patients to aid early diagnosis and treatment in an effort to limit the outbreak.

### P17 ELEVEN MEN WITH PROCTITIS: A CASE SERIES OF RECTAL BIOPSIES FROM MALE PATIENTS SUBSEQUENTLY DIAGNOSED WITH LYMPHOGRAULOMA VENEREUM PROCTITIS

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**Introduction:** The first UK cases in the recent outbreak of lymphogranuloma venereum (LGV) proctitis among men who have sex with men were recognised in late 2004. Since that time it has become apparent that LGV was the likely cause of disease in many men who had been diagnosed with "non-specific" proctitis in the preceding two years. These men had undergone many investigations for their symptoms including colorectal endoscopy and biopsy.

**Methods:** We reviewed the clinical notes and histopathological specimens of 11 such men who were investigated at our hospital and were diagnosed with LGV proctitis at a later date.

**Results:** The majority of these men were HIV positive and had symptoms of severe proctitis. Most biopsies showed severe inflammatory changes often with ulceration and crypt abscesses. Distortion in the crypt architecture was less common and "proctitis of an infective origin" was often suggested, though LGV was not usually proffered as a specific cause. All men were diagnosed subsequently with LGV by isolation of L-serovar *Chlamydia trachomatis* from rectal swabs or by serology showing high titre to L2 antigen using the whole cell inclusion immunofluorescence (WIF) assay.

**Conclusion:** LGV proctitis causes non-specific inflammatory histological changes in the rectal mucosa that are easily mistaken for other pathologies such as inflammatory bowel disease. Surgeons, gastroenterologists, and pathologists should be aware of the current epidemiology of LGV in the UK and include LGV in the differential diagnosis of proctitis among patients with a relevant risk history.

### P18 PREVALENCE OF RECTAL CHLAMYDIAL INFECTION AMONG A COHORT OF LONDON MEN WHO HAVE SEX WITH MEN

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**Introduction:** A recent outbreak of lymphogranuloma venereum (LGV) proctitis among UK men who have sex with men (MSM) prompted routine screening for rectal chlamydial infection in our gay men's clinic. We sought to estimate the prevalence of asymptomatic rectal chlamydia infection and analyse clinical features and risk factors.

**Methods:** All MSM presenting to a dedicated after hours gay men's clinic in London were offered rectal chlamydia screening using BDProbeTec SDA on rectal swab samples taken by clinic staff in addition to the usual sexual health screen. Positive samples were referred to the Health Protection Agency where the presence of chlamydial DNA was confirmed using molecular techniques. Further typing of positive samples was done to distinguish between LGV and non-LGV infection. Clinical records and laboratory results were reviewed to characterise chlamydia positive patients and compare these men those who tested negative.

**Results:** Overall prevalence of rectal chlamydia was over 5% among our cohort of over 250 MSM patients. The BDProbeTec had a low rate of false positives when used to test from the rectum—a site for which it is not yet licensed in the UK. Updated data on prevalence, clinical features, and risk factors for rectal chlamydial infection will be presented.

**Conclusion:** Asymptomatic rectal chlamydial infection was more common than urethral infection among our MSM patients. Our standard chlamydia test kit performed well at the rectal site and we feel that routine screening for rectal chlamydia is warranted among this population.

Abstract P16 LGV cases and concurrent STIs

Cases of rectal LGV	Asymptomatic rectal LGV infection	Concurrent gonorrhoeal infection	Concurrent syphilis	Known HIV positive	Known hepatitis C positive
11	3 (27.3%)	3 (27.3%)	1 (9.1%)	5 (45.5%)	1 (9.1%)

**P19 MEASURING DIAGNOSED CHLAMYDIA TRACHOMATIS IN A UK POPULATION: ASSESSMENT OF CROSS BORDER FLOW AT NEIGHBOURING GENITOURINARY MEDICINE CLINICS**

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**Background:** The open access to GUM clinics can lead to under-estimation of local STI prevalence if residents choose to visit a neighbouring clinic for their STI care.

**Objective and Method:** To estimate this cross border flow, six clinics neighbouring the Leeds GUM centre were asked to supply aggregate data on Leeds residents (identified by postcode) diagnosed with chlamydia in 2003–04.

**Results:** 104 chlamydia episodes were recorded, with the majority from the nearest urban centre (Bradford clinic 72/104 or 69%). This compares to 5146 episodes diagnosed in Leeds residents during the same period at Leeds healthcare sites, with 2128 (41%) diagnosed at Leeds GUM and 2653 (52%) at community sites. As at Leeds GUM, most cases were seen in males 54/103=52%, aged 20–24 years (45/103=44%), and of white ethnicity (56/72 or 78%). Most patients were of a less socioeconomically deprived group (Townsend Deprivation Quintile 4 in 26/89 or 29%) than their counterparts attending with chlamydia to the Leeds GUM clinic (Quintile 4 in 234/2128 or 11%, OR 3.34 (95% CI 2.02 to 5.51)  $p < 0.001$ ).

**Conclusions:** There was relatively little (2%) chlamydia diagnosed in Leeds residents attending to non-Leeds GUM clinics for care. Cross border flow issues may now be of more concern regarding GP and community testing centres, particularly those near to PCT and SHA borders. Demographics were similar in patients diagnosed at Leeds and non-Leeds clinics but patients attending outside Leeds were more affluent. This may reflect greater affluence at border areas or a greater means to exercise a preference for a clinic site elsewhere.

**P20 THE ASSESSMENT OF CHLAMYDIAL LOAD IN URINE AND VULVO-VAGINAL SWABS IN A COMMUNITY SETTING USING QUANTITATIVE REAL-TIME PCR, AND COMPARISON WITH RESULTS FROM ENZYME LINKED IMMUNOASSAYS**

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**Introduction:** In this study, frozen female vulvo-vaginal swab (VVS) and male first-catch urine (FCU) from NAAT chlamydia positive specimens from the Chlamydia Screening Study (CLaSS) study were used to determine chlamydial load in the original EIA reaction using quantitative polymerase chain reaction (qPCR).

**Methods:** Thirty nine women and 17 men were studied and samples were taken at two visits three weeks apart. *C. trachomatis* had been detected using Roche-Cobas PCR and Dako PCE-EIA. Nucleic acids were extracted from FCU and VVS and qPCR undertaken using an Applied Biosystems-7500. Groups were compared using *t* tests.

**Results:** At presentation and follow up specimens that were PCE positive had a significantly greater number of *C. trachomatis* genomic copies per EIA reaction mix than PCE negative individuals (Visit 1: *t* test:  $p = 0.015$ , the mean for PCE-positive, 3.32, SD, 1.71; mean for PCE-negative, 2.04, SD, 1.68 and Visit 2: *t* test:  $p = 0.003$ , the mean for PCE-positive, 3.54, SD, 1.33; mean for PCE-negative, 2.21, SD, 1.13).

**Discussion:** This study demonstrates that PCE-positive specimens have a greater number of *C. trachomatis* genomic copies present compared to PCE negative patients. However the EIA was able to detect six specimens in which fewer than 10 genomic copies were present and missed two specimens in which over 10 000 copies were present. This suggests that detection of *C. trachomatis* by EIAs which detect LPS is more complex than one of a simple cut-off based on infecting load as suggested by in vitro experiments. One possible explanation is latency which results in down regulation of lipopolysaccharide production. This requires further investigation.

**P21 DOES URINE AS SPECIMEN TRANSPORT MEDIUM FOR URETHRAL SWABS FOR DETECTION OF CHLAMYDIA TRACHOMATIS BY POLYMERASE CHAIN REACTION DETECT MORE CASES THAN URETHRAL SWAB IN 2SP MEDIUM OR URINE ALONE?**

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**Background:** This is a prospective study to look at the feasibility of using patient's urine instead of 2Sucrose Phosphate (2-SP) as transport medium for endourethral swabs from men, for detection of chlamydia trachomatis by polymerase chain reaction (PCR). This also allowed comparison of endourethral swabs alone, endourethral swabs in urine and urine alone as diagnostic specimens for diagnosing genital chlamydia.

**Methods:** Two endourethral and first voided urine specimens were taken from 350 male patients. The first swab was used for microscopy and culture for *Neisseria gonorrhoeae*, before being placed in one of the aliquots of urine. The second swab was placed in 2-SP. The other aliquot of urine was the third specimen. All the three specimens were tested using the Roche Cobas Amplicor PCR, with internal control. A diagnosis of genital *C. trachomatis* was made if any one of the specimens tested reproducibly positive.

**Results:** Chlamydia trachomatis DNA was detected in 163 (46.6%) of the total 350 patients in the study. In 119 of the 163 patients (73%), all the three genital specimens were positive. Among the 44 discrepant results, 32 (73.6%) had a positive result from the first swab, compared to 24 (54.5%) from the second swab and 24 (54.5%) from urine. There were a total of 18 samples, which gave either inhibitory or equivocal results among these specimens.

**Conclusion:** The results, while proving urine as an excellent transport medium, questioned the value of the second swab and urine alone as the best diagnostic specimen for chlamydial infection in men.

**P22 A COMPUTER BASED NON-URINE, NON-SWAB SIMPLE POINT OF CARE DIAGNOSTIC TEST FOR CHLAMYDIA TRACHOMATIS**

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**Background:** Point of care tests for *Chlamydia trachomatis* (POC-CT) may reduce prevalence rates. Modern desktop based data learning tools can be trained to recognise patterns in clinical data to aid diagnosis. We assessed the diagnostic accuracy of a number of these tools to predict CT in men.

**Methods:** Data from equal numbers of CT positive and negative patients form a training set. The software learns patterns for CT on the training set and then tests their diagnostic accuracy on a separate testing set. By randomly mixing and producing multiple training and testing sets a truer assessment of accuracy is attained (cross validation). Improved diagnostic accuracy is achieved by employing weighted voting (boosted learning) for different patterns recognised. Clinical notes of 150 CT positive cases and 150 CT negative controls were examined retrospectively. 34 clinical attributes (for example, age, ethnicity, symptoms, etc) were identified for training. The model was tested with and without urethral-smear polymorph count ( $\geq 5$ /hpf, PMN), which generally has moderate sensitivity (60–80%) and specificity (60–80%) as a POC-CT.

**Results:** On small subset preliminary analysis, sensitivity/specificity for training alone and after cross validation equals 100%/100% and 85.4%/82.9% respectively. When PMN is removed as an attribute from the model, sensitivity/specificity equals 100%/100% and 80.5%/75.6% respectively.

**Conclusions:** On initial analysis, machine learning on clinical data alone may perform as accurately or better than PMN as a POC-CT. This may be useful for guiding immediate treatment and partner notification interventions when other POC-CTs are not available or acceptable. A full analysis will be presented at the conference.

**P23 EVALUATION OF A DROP-IN SELF-ADMINISTERED CHLAMYDIA TESTING SERVICE**

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Many GU clinics have triage systems to fast track some groups. This means that others (particularly asymptomatic heterosexuals aged over 20) have difficulty getting an appointment. Many of these people will have chlamydia.

We set up a service where non-fast tracked people could have a chlamydia test with minimal impact on the workload of the clinic.

People who were not eligible for a fast track appointment were given the option of self-testing, the limitations being clearly explained. On registering, patients completed a screening questionnaire which detected people who might be better seen in a full consultation. Completed questionnaires were reviewed by a receptionist and if necessary the person was triaged by a health adviser to decide whether self-testing was appropriate. If suitable, the receptionist gave an instruction sheet and sampling equipment to the patient.

Men gave a FVU specimen and women collected a low vaginal specimen using a swab. BD Probetec SDA was used for analysis. Patients completed an evaluation form, departed, and were phoned by a health adviser if the test was positive, invalid, or inadequate. The results (August 2004 to August 2005) are shown in the tables. 15% of people declined self-testing, preferring to wait for a full consultation. 88 evaluation questionnaires were at least partially completed.

Comments included "very helpful", "professional", and "didn't have a lot of confidence on self-swabbing. Would prefer nurse to do it". Self-testing can increase throughput in low capacity services where gonorrhoea is uncommon. Most patients like it although a minority of women report difficulty self-swabbing.

#### P24 PREVALENCE OF CHLAMYDIA TRACHOMATIS AMONG FEMALE STUDENTS ATTENDING HEALTH UNITS AT THREE THIRD LEVEL COLLEGES IN IRELAND

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**Background:** *Chlamydia trachomatis* is the second most commonly notified sexually shared infection (SSI) in Ireland. Infection in women is often asymptomatic but may be associated with complications including pelvic inflammatory disease and infertility. Notifications increased from 245 cases in 1995 to 2803 in 2004.

**Aim:** To anticipate the need for prevalence data identified by the Health Protection Surveillance Centre, a study was set up to determine the prevalence of *Chlamydia trachomatis* genital infection in a student population.

**Methods:** All female attendees presenting during one day periods at Student Health Units in three institutions in two cities were invited to participate. Excluded were those presenting for investigation of SSI or presenting with symptoms suggestive of SSI. Participants self-completed a questionnaire and provided a urine sample. Samples were tested by a PCR based technique (Cobas Ampicor, Roche). Participants were referred for advice as well as screening for coexisting SSIs.

**Results:** Of the 489 participants, 29 indicated not being sexually active (NSA) and 11 invalid tests returned (presence of inhibitors). Of the 450 participants included in the analysis, 22 tested positive (4.9%). 109 (24.3%) sexually active female students indicated suggestive symptoms of SSI without presenting for this; including 10 (45.4%) out of the 22 chlamydia positive group. Further multivariate analysis is planned to explore other possible risk factors of chlamydia infection.

**Conclusions:** A prevalence of 4.9% *C trachomatis* infection among sexually experienced female students of whom many were unaware of the potential significance of symptoms, urges the need for a programme to detect asymptomatic women.

#### P25 CHLAMYDIA SCREENING IN TRIAGE

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**Background:** Due to huge demand on and restricted access to our sexual health clinic we introduced opportunistic screening for chlamydia (CT) using non-invasively collected specimen for patients attending triage.

**Objectives:** To determine uptake of chlamydia testing in patients seen for triage and to determine the prevalence of CT in this population.

#### Abstract P23, table 2

##### Why did you use the self-test service?

Didn't want to wait for a full check up	37/85 (43.5%)
I was only concerned about chlamydia	35/85 (41.2%)

**Methods:** Prospective audit of all patients attending a North London sexual health clinic for triage between 06/05 and 09/05 and who were assessed as not needing urgent medical treatment.

**Results:** Preliminary results of 129 eligible patients (78 women, 51 men) suggest that 57 (44%) were offered CT screening in triage and of those 26 (46%) accepted the offer. Twenty (77%) of the patients tested were under the age of 25 and five (19%) were male. Three patients (all women under the age of 21) tested positive for CT (12%). All were treated successfully within nine days of testing. Further data and analysis will be presented at the conference.

**Conclusion:** Patients attending sexual health clinics for triage are at high risk of infection with genital CT. Opportunistic screening for CT should be considered in patients unable to be offered a full sexual health screen in particular to those under the age of 25.

#### P26 P IN THE POST OR T IN THE POST: WHAT WOULD PATIENTS PREFER?

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**Introduction:** Novel interventions to improve partner treatment rates among women with chlamydia have been proposed. However, little is known regarding the acceptability of such strategies.

**Methods:** 110 chlamydia positive women, participating in a randomised study comparing three partner intervention strategies were asked (a) which option they would have preferred for their partner if given a choice and (b) which strategy they would prefer for themselves, if their partner was first to be diagnosed with chlamydia: (1) standard contact tracing (CT), (2) patient-delivered partner medication (PDPM) of 1 g azithromycin, or (3) postal testing kit (PTK) for urine testing.

**Results:** Concerning partners, 72 (65%) women preferred PDPM, 23 (21%) had no preference, 10 (9%) preferred CT, and five (5%) PTK. The commonest reasons for choosing PDPM for partners were that it was simple/convenient, that men would be treated more quickly and would not need to attend a clinic. Those preferring CT believed men should accept responsibility and get a STI screen. Regarding personal preference, 64 women (58%) preferred PDPM (for the same reasons), 29 (26%) CT, nine (8%) had no preference, and three (3%) preferred PTK. Five women (5%) stated that they would wish a combination of PDPM with CT or PTK.

**Discussion:** If offered the choice, the majority of women with chlamydia would choose PDPM for both partners (and themselves), primarily because of perceived convenience. Very few would choose a PTK. Whether PDPM is as efficacious as CT or PTK in terms of partner treatment rates remains to be established.

#### P27 DOES SCREENING FOR CHLAMYDIA TRACHOMATIS AND NEISSERIA GONORRHOEA USING PCR/TMA ON FIRST VOID URINE IN ASYMPTOMATIC MALES MISS PATIENTS WITH NON-SPECIFIC URETHRITIS?

R. K. Ellks, M. Gupta, A. B. Alawattagama. Department of GUM, Royal Liverpool University Hospital, Prescot Street, Liverpool L7 8XP, UK

**Background:** Due to a rising workload in GUM increasing numbers of GUM clinics screen asymptomatic male patients for chlamydia (CT) and gonorrhoea (GC) using PCR/TMA on first void urine. We believe this

#### Abstract P23, table 1

	Subjects	Invalid or inadequate	Positive	% positive (binomial CI)	Respondents saying self-testing was "easy" or "very easy"
Men	60	2	6	10% (3.8 to 20.5)	41/41 (100%)
Women	51	3	10	19.6% (9.8 to 33.1)	38/40 (95%)



policy may leave a substantial number of patients with non-specific urethritis (NSU) untreated.

**Aim:** To identify the numbers of asymptomatic male patients with CT and GC negative NSU who would be deprived of treatment had we exercised the above policy.

**Method:** All asymptomatic male patients attending GUM services for sexual health screening during a random calendar month were identified and their records reviewed. Age, sexual practice, and details of known contact with infection were recorded. Findings on examination and microscopy were then compared with results of endourethral swabs for CT and GC.

**Results:** Of the 124 asymptomatic male patients identified 29 (23.4%) were contacts of CT. Of these 10 were positive for CT and two GC. In the remaining 95, seven were positive for CT. 105 patients were CT and GC negative, of which 22 (21%) had asymptomatic NSU (>5 Pus cells/field).

**Conclusion:** These results show that 21% of asymptomatic patients attending our GUM clinic would not have had treatment for NSU had they been screened by urine testing alone. Had all contacts of CT been given epidemiological treatment irrespective of CT/GC results, this would still leave 15 (12.1%) patients undiagnosed and untreated had urethral microscopy not been performed.

## P28 DOES PARTNER NOTIFICATION OF MEN WITH ASYMPTOMATIC NON-GONOCOCCAL URETHRITIS IDENTIFY CHLAMYDIA POSITIVE WOMEN?

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**Background:** It has been suggested that urethral microscopy on asymptomatic men attending genitourinary medicine clinics causes unnecessary anxiety for the patient and is not cost-effective. We sought to establish whether identifying men with asymptomatic non-gonococcal urethritis (NGU) also identifies chlamydia-positive women, through partner notification, who otherwise would not have been screened. If correct this may be an argument for continuing urethral microscopy on asymptomatic patients.

**Method:** Men diagnosed with NGU over a three month period were identified via the KC60. The notes were reviewed retrospectively and were excluded if coded incorrectly or if the patient was exclusively homosexual. Data collected from the notes included demographic details, presence or absence of symptoms, and details of the partner notification process. Notes of female partners who had attended were reviewed and details of positive swab results or clinical findings of mucopurulent cervicitis or pelvic inflammatory disease (PID) were recorded.

**Results:** Preliminary analysis has shown that of the patients diagnosed with NGU during the study period 47% were asymptomatic. In the female partners successfully traced 33% had a positive chlamydia result and were treated appropriately. There was no significant prevalence of mucopurulent cervicitis or PID. Further analysis of data will be presented.

**Conclusion:** Partner notification of men with asymptomatic NGU does identify additional chlamydia positive women. However, this needs to be balanced with the service pressure caused by urethral microscopy and the consequent reduction in capacity to see other patients. In addition, the low acceptability of urethral sampling in asymptomatic men must be considered.

## P29 HOW SHOULD WE FOLLOW UP PATIENTS DIAGNOSED WITH NON-GONOCOCCAL URETHRITIS?

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**Background:** Modernisation of GUM clinics is urgently required to increase capacity. National guidelines advise follow up of non-gonococcal urethritis (NGU) patients at two weeks, but clear evidence is lacking.

**Aims:** To determine the outcome of NGU follow up.

**Methods:** Retrospective case note review of men diagnosed with NGU during a three months period at two North London GUM clinics. Data were collected on demographics, sexual orientation, reason for attendance, management, and follow up.

**Results:** Over 600 patients were diagnosed with NGU in the study period. Of 100 cases analysed so far: median age 28 years. 64% attended because of symptoms, 9% were a contact, and 36% were asymptomatic. Of symptomatic individuals, median duration of symptoms was 23 days. After treatment, partner notification was advised in

78%, and follow up appointment booked as per clinic protocol in 97%. 70/97 (72%) attended follow up appointment. Of these 61/70 (87%) had completed prescribed treatment and 50/70 (71%) had abstained from sex. Partners had been treated in only 28%. Of those attending, 11/70 (16%) were still symptomatic. 9/11 of these had repeat microscopy, positive in two cases. 11 individuals were retreated: two due to persistent NSU, seven due to non-compliance or sex during treatment, and two due to other reasons. Nine patients were not retreated despite indication. Full results and analysis to follow.

**Discussion:** Although attendance at follow up was good, only 16% of men remained symptomatic, and two were diagnosed with persistent NSU. We believe follow up could be provided by phone without compromising quality of care.

## P30 IS ROUTINE MICROSCOPY IN ASYMPTOMATIC FEMALES BENEFICIAL?

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**Background:** Due to an increasing workload many GUM clinics have decided to screen asymptomatic female patients using a first void urine sample for chlamydia and gonorrhoea PCR/TMA. We audited the feasibility of this screening technique.

**Method:** We reviewed the records of all asymptomatic female patients attending GUM services requesting an STI screen during a random calendar month. Patients' records were reviewed for age, contact with infection, symptoms, microscopy results, treatment issued, and final diagnosis after culture/PCR analysis.

**Results:** 100 women: Two pregnant women both contacts of infection. Three sexual assaulted. Eight were contacts of CT and five were found to be CT positive. One GC contact who was GC positive. One contact of CT and GC who was positive for both organisms. 12 contacts of non-specific urethritis (NSU), four identified as CT positive. Vaginal microscopy: 19 *Bacterial vaginosis* (BV) four received treatment after microscopy results. 17 candida on microscopy; six received treatment. Of the remaining 75 women who were not known contacts of infection, seven were found to have CT and one GC. No cases of asymptomatic *Trichomonas vaginalis* were identified during this study period.

**Conclusion:** Of the 95 women who were asymptomatic and did not require examination on clinical grounds microscopy changed the management in 11 women (4 BV, 6 candida, 1 GC). This may suggest that it is possible to screen asymptomatic women who do not require examination on clinical grounds to be screened with urine testing alone for CT and GC.

## P31 MANAGEMENT OF VAGINAL DISCHARGE: IS MICROSCOPY AN ESSENTIAL TOOL?

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Evidence based modernisation of procedures in sexual health clinics is urgently required to cope with increasing demand. We conducted a prospective study of the additional benefit of on-site microscopy over clinical assessment in the diagnosis of vaginal discharge, powered to detect a 10% rate of missed diagnosis, at two London GU clinics. Age, ethnicity, pH, and a clinical diagnosis were recorded for each patient and subsequently microscopy findings were added. Clinical diagnosis was compared with same day microscopy diagnosis (lab day 1) and with culture results (lab day 7).

We compared a positive BV clinical diagnosis (symptoms, signs and pH>4.5) with the gold standard diagnosis, defined as presence of clue

### Abstract P31

	BV clinical diagnosis inc pH v lab day 1		Candida clinical diagnosis v lab day 1	
	Clinic 1, n = 84	Clinic 2, n = 37	Clinic 1, n = 117	Clinic 2, n = 27
Sensitivity	89%	53%	62%	53%
Specificity	87%	92%	73%	92%
Overall rate of missed diagnosis	1.6%	5.2%	5.3%	5.4%

cells, symptoms, and pH>4.5. For Candida infections we compared clinical diagnosis with day 1 and day 7 laboratory results. A total of 560 women were entered into the audit. Sensitivity and specificity of BV and Candida clinical diagnoses are presented in the table.

The diagnosis made on clinical grounds is setting specific but acceptable for diagnosing vaginal discharge in the absence of microscopy. Detailed analysis and data on the influence of age and ethnicity on the sensitivity and specificity of clinical diagnosis will be presented.

### P32 DO HIGH VAGINAL CULTURE AND URETHRAL CULTURE MAKE A USEFUL CONTRIBUTION TO DIAGNOSES WHEN MICROSCOPY IS AVAILABLE?

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**Background:** Currently, all female patients attending the clinic are offered a full STI screen with High Vaginal Swab:

- *Trichomonas vaginalis* on wet film, *Bacterial vaginosis*, Candida, and pus cells on gram stained film. High Vaginal Swab culture for Candida and *Trichomonas* confirmation.
- Cervical swab/urethral swab: gram stain for pus cells and intracellular gram negative diplococci. Culture for *Neisseria gonorrhoea*.

**Aim:** To assess the usefulness of HVS culture when on site microscopy of gram stained and wet film HVS is available. Assess the usefulness of routine urethral swab test in females and whether this gives additional diagnosis of gonorrhoea.

**Method:** Retrospective case note review of 122 females with an S1 or S2 diagnosis.

**Results:** Of the 122 patients included in the audit, 105 patients had a negative high vaginal culture and 120 patients had a negative urethral culture. The two cases of gonorrhoea isolated on urethral culture were also isolated on the cervical microscopy and culture for these patients. Of the nine cases where Candida was isolated on culture but negative on microscopy, eight of these patients were asymptomatic and therefore did not require treatment. The one symptomatic patient was recalled for treatment. The patient with *Trichomonas* on wet film was negative on culture.

**Conclusion:** High vaginal culture and urethral culture do not offer a useful contribution in the diagnosis of additional infections in women who have undergone screening in a setting where microscopy is available.

### P33 A NEW ASPECT ON GENITOURINARY MEDICINE CLINIC DESIGN

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Coincident with the availability of money for new infrastructure, Sheffield GUM, like many other clinics currently, has the opportunity to expand its clinical space. The Sheffield clinic is now working at full capacity, with space as the major limiting factor to meeting the 48 hour waiting targets by 2008.

As part of a university project, Sheffield University architecture students undertook to design a clinic which would best meet the current and future needs of both patients and staff using specific healthcare architecture tools and techniques.

The design process involved the use of different images to provoke discussion among staff as to the ideal clinic environment. From the patient perspective the students used a healthcare environment calibration tool, called the "ASPECT" score, to grade the existing and projected clinics in terms of: privacy/dignity, views, nature/outdoors, comfort/control, legibility of place, interior appearance, facilities, and staff facilities. The existing clinic scored poorly in all categories (1.0–3.5 out of a maximum 6.0). The minimum requirement for new PFI builds is a score of 4.0.

The students were able to use these techniques to design not only a novel new clinic space, but also different templates for how a generic GUM clinic might be created.

It is essential for us to see our physical environment through patients' eyes, and to use newly available resources such as the Centre for Healthcare Architecture and Design to ensure all our new clinics are patient friendly, stigma reducing environments.

### P34 PATIENT PERSPECTIVES ON ESSENTIAL FEATURES OF A SEXUAL HEALTH SERVICE

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**Background:** Amid initiatives to improve Sexual Health services in the UK, we set out to determine what GUM clients view as essential features of a Sexual Health service.

**Methods:** 100 male and 100 female new attendees to a GUM clinic in SW London completed a questionnaire by rating 28 features of hypothetical sexual health service, on a modified Likert scale. The features were then ranked by these ratings and also analysed according to subgroups such as age, sex, and presence of symptoms of the responders who rated them.

**Results:** Many features did not generate strong positive or negative feelings. The top five were: "staff being specialist in STIs", "walk-in access", "opening every weekday", "HIV testing", and "immediate testing and diagnosis". Percentages of subjects giving top rating being: 73.5%, 63.8%, 61.4%, 60.4%, and 59.1% respectively. The least well regarded feature was "service limited to one-two days opening weekly", with a percentage for the negative ratings of 70.6%. "Free condoms" ( $p<0.05$ ) and "emergency contraception" ( $p<0.01$ ) were significantly better regarded by women. "Free prescriptions" ( $p<0.01$ ), "emergency contraception" ( $p<0.005$ ), "staff specialising in family planning" ( $p<0.05$ ), and "single-sex waiting rooms" ( $p<0.025$ ) were significantly better regarded by under 25s than others. Having symptoms did not significantly affect responses.

**Conclusions:** Clients rate seeing a specialist in STIs as the most important feature of a sexual health service. Maintaining open access and provision of HIV testing are also vital. These features along with knowledge of the demographics of expected clients must be considered when planning sexual health care.

### P35 THE SANDYFORD INITIATIVE AS A MODEL OF A SEXUAL HEALTH SERVICE IN THE 21ST CENTURY

C. Cunningham, A. Winter, R. Nandwani. *The Sandyford Initiative, Glasgow, UK*

**Introduction:** The imperative to modernise has focussed attention on the need to develop the existing service to deliver faster, better quality, and more patient centred care.

**Methods:** A description of service development within the Sandyford Initiative from 2000 to the present.

**Results:** The Sandyford Initiative was established in 2000 from the integration of: (1) Family Planning and Reproductive health, (2) Genitourinary Medicine and Sexual health, (3) The Steve Retson Project (SRP) for gay and bisexual men, and (4) The Centre for Women's Health (counselling services, library, and information services). The Initiative joined established services including the HIV service, Base 75 service (healthcare for women involved in prostitution), and Sappho service (clinical and counselling services for lesbian and bisexual women).

Since this time selected service improvements have included: (1) Clinical Service: introduction of "The Place" a dedicated young persons clinic, "Corner Clinic" a Nurse-led clinic providing sexual health screens for asymptomatic patients, satellite clinics under the brand names "Sandyford" and "The Place", (2) Counselling: generic counselling services including alcohol and addiction for young people, "Thrive" for men who have experienced childhood sexual abuse, (3) Information Technology: introduction of computerised clinical database, (4) Laboratory Testing: urine PCR chlamydia tests, same day testing for HIV and withdrawal of microscopy on asymptomatic patients, (5) Nurse Competencies: asymptomatic screening, nurse-led clinics, and prescribing.

**Discussion:** The evolution of this service represents a model of development of a comprehensive sexual health service. I will present details of other developments and their impact on service delivery including case mix and patient numbers.

### P36 ARE RAPID ACCESS CLINICS THE WAY FORWARD TO IMPROVE ENTRY TO SEXUAL HEALTH SERVICES?

L. Tucker, V. Harindra. *Department of Genitourinary Medicine, St Mary's Hospital, Milton Road, Portsmouth, Hampshire, PO3 6AD, UK*

**Introduction:** The UK's sexual health has worsened over the last decade with high levels of sexually transmitted infections (STIs) and unacceptably



long waiting times to access genitourinary medicine (GUM) services. Our GUM service responded by introducing a triage system in 1998, those who do not fit the triage criteria made a routine appointment which in early 2004 could be 3–4 weeks which we thought an unacceptable level of service. At the same time (25%) of patients failed to keep their appointment. In April 2005 the department re configured its services, reduced booked appointments, and increased the times where patients could have rapid access to GUM services. The majority of the rapid access clinics are nurse led with access to a doctor when required.

**Method:** A prospective study of 376 female and 306 male patients attending the rapid access clinic consecutively for four weeks from April 2005 was undertaken. 169 (55%) men and 126 (34%) women were diagnosed with an STI and a further 22 (7%) men and 54 (14%) women required treatment for other conditions.

**Results:** This presentation will discuss:

- How we achieved a 48 hour access target within existing resources.
- That preliminary diagnosis and management by nurses was consistent with the final diagnosis.
- How a triage system may miss asymptomatic patients with STIs.
- That leadership and enhanced opportunities for nurse's lead to the recruitment and retention of an extremely skilled nursing team.
- How access was improved for all patients but in particular young people.

### P37 "GUM LITE !" PROCESS AND PATIENT SATISFACTION

A. M. Wright, C. A. Bowman, H. Arnot, G. R. Kinghorn. *Department of Genitourinary Medicine, Royal Hallamshire Hospital, Sheffield Teaching Hospitals NHS Foundation Trust, UK*

Availability of nucleic acid amplification tests for chlamydia and gonorrhoea allowed us to introduce a package tailored to asymptomatic patients wanting STI screening with minimal fuss! The Fast Track Asymptomatic STI screening service (FASS) was introduced in August 2005. (See also *Towards 48 hour access: impact of fast track asymptomatic sexually transmitted infection screening clinics* by the same authors.)

FASS is different from a traditional GUM clinic visit. Clear understanding of this was crucial to successful implementation.

Process design:

- staff awareness of the purpose and restrictions of FASS
- appropriate patient exclusion criteria
- information to patients to empower them to select this service appropriately
- patient self-administered questionnaires to streamline history taking
- prospective monitoring of patient satisfaction.

Only chlamydia (CT), gonorrhoea (GC), syphilis, and HIV are tested for. These fulfil disease screening criteria: may be present asymptotically, have sensitive and specific tests, have serious sequelae if untreated, have effective treatment which reduces long term sequelae and transmissibility.

Prospective patient evaluation and feedback has been very positive. Patients particularly liked rapid access to this service and very short time spent in clinic. Full details will be presented

**Conclusion:** FASS is popular and effective for asymptomatic patients and increases choice in sexual health provision.

Abstract P37 Patient attendances in the first 16 weeks

	Patients booked (mean)	Patients attended (mean)	Mean% DNA	Symptomatic patients (mean)
Females	239 (15)	203 (13)	16%	16 (7%)
Males	259 (16)	214 (13)	17%	41 (16%)
Total	498 (31)	417 (26)	16.5%	57 (11%)

### P38 TOWARDS 48 HOUR ACCESS: IMPACT OF FAST TRACK ASYMPTOMATIC SEXUALLY TRANSMITTED INFECTION SCREENING

C. A. Bowman, A. M. Wright, H. Arnot, G. R. Kinghorn. *Department of Genitourinary Medicine, Royal Hallamshire Hospital, Sheffield Teaching Hospitals NHS Foundation Trust*

Demand on GUM services continues to grow. Health Protection Agency May 2005 waiting times survey of GUM clinics showed 24% of patients attended our clinic within 48 hrs compared with 45% nationally. 47% waited more than two weeks (compared with 25% nationally).

We introduced Fast Track Asymptomatic STI Screening Clinics in August 2005 and real-time monitoring in October 2005

Objectives were:

- to move towards 48 hour access target
- to meet local demand for comprehensive STI and HIV screening in a GUM setting
- to free up resources for managing more complex GUM conditions
- to reduce DNA rates
- to reduce undetected STIs and HIV.

In November 2005, 58% of women and 36% of men were offered appointments within 48 hours. "First available appointment  $\geq 6$  days" fell to 8% of patients. 46% of patients attended GUM within 48 hours and less than 3% waited over two weeks for an appointment. By December 2005  $\geq 66\%$  of patients were offered appointments within 48 hours and two week wait was 0.

Total attendance figures rose by 12% from 2374 in May to 2647 in November. DNAs for new patients fell from 32% to 20% in these respective months

Prospective patient evaluation was very positive. Of 332 patients seen in the first three months the following new infections were identified: chlamydia, 32; gonorrhoea, 6; HIV, 1; infectious syphilis, 1.

**Conclusion:** Fast track Asymptomatic STI Screening clinics can have a significant impact on reducing waiting times to GUM appointments and help tackle undiagnosed STIs and HIV.

### P39 USE OF THE PATIENT SELF-TRIAGE TO INCREASE ACCESS

R. Rani, W. Tsang, H. Lewis-Parmar. *Tameside and Glossop Centre for Sexual Health, UK*

**Introduction:** A nurse led service for screening of asymptomatic new cases was introduced to increase access at Tameside and Glossop Centre for Sexual Health within existing resources. To facilitate appropriate selection of asymptomatic cases all new attendees are asked to complete a Patient Self-Triage Form. Patients who report no symptoms and attending for "peace of mind" or as a contact are allocated to the nurse for screening.

**Aims:** To assess the effectiveness and suitability of the Patient Self-triage in identifying asymptomatic cases for the nurse led service.

**Method:** Review of Patients Self-Triage Forms in relation to case notes for new cases seen in March 2005. Data analysis using Excel.

**Results:** Data on randomly selected 123 new cases seen in March 2005 are presented. Patients reported presence or absence of symptoms on

Abstract P39, table 1

Self-Triage Form	Clinical history	Patients (n)
Asymptomatic	Asymptomatic	36
Symptomatic	Symptomatic	64
	Total	100 (81%)

Abstract P39, table 2

Self-Triage Form	Clinical history	Final result	Patients (n)
Asymptomatic	Asymptomatic	Negative	26
Symptomatic	Symptomatic	Positive	48
		Total	74 (60%)

the Self-Triage Form matched well with clinical history in 100 (80%) of the 123 cases (table 1). Similarly, there was good match in relation to reported symptoms, clinical history, and final diagnosis among 74 (60%) cases (table 2). There was no match in 22 cases, of these 21 patients who had reported no symptoms had symptoms in clinical history.

**Conclusions:** Patient Self-Triage form is a useful tool in allocating appropriate cases to the nurse led service.

#### **P40 IMPACT OF A NURSE PRACTITIONER POST ON PATIENT ACCESS IN A DISTRICT GENERAL HOSPITAL GENITOURINARY MEDICINE DEPARTMENT**

C. A. Bowman, K. Wainwright, S. Hinchliffe. *Department of Genitourinary Medicine, Rotherham District General Hospital NHS Foundation Trust, UK*

**Introduction:** Our new patient attendances increased from 2955 in 1999 to 4576 in 2004. Health Protection Agency (HPA) Waiting times survey May 2005 showed that only 28% of patients were seen in <48 hours, 24% in three days to two weeks and 48% in over two weeks. This compares badly to the overall national figures of 45%, 30%, and 25% respectively. Lack of medical staff has compounded access and training difficulties.

**Methods:** In June 2005 a new GUM service strategy and development plan was agreed. This included introduction of a nurse practitioner post. The NP sees new and follow up patients and prescribes treatments for agreed infections under patient group directives. NP also helped instigate and run a fast track STI screening service. We have evaluated impact on waiting times. A patient satisfaction survey was also performed.

**Results:** Marked reduction of mean waiting times to appointments from a mean of over 17 working days to five days for women and 10 days for men. Subsequent introduction of a fast track asymptomatic screening clinic has increased access further. An evaluation of the impact of the nurse practitioner on access and patient satisfaction is presented.

**Discussion:** Nurse practitioner posts can play a key role in improving access to GUM services. Patient satisfaction with this service is high.

#### **P41 QUICK CHECK: A NURSE LED SERVICE FOR THE WORRIED WELL**

J. Sherrard, C. Brotherton, A. Worlock, M. Rings. *Department of GUM, Radcliffe Infirmary, Woodstock Road, Oxford OX2 6HE, UK*

A nurse led, drop in service for the "worried well" was established in February 2003, with the aim of providing testing for STIs for asymptomatic individuals who are not known to be STI contacts, in response to access pressures on a GUM clinic.

All patients have a sexual history taken. Tests available include HIV, hepatitis B, C, and syphilis serology, cervical cytology, chlamydia, and pregnancy testing. Wart treatment, emergency contraception, and hepatitis B vaccination are available. Patients identified with an infection are offered a full screen. Symptomatic patients and contacts of infection are booked into the following day's routine clinic for a full STI screen and treatment as appropriate. All other patients telephone for their results including HIV test.

Attendances have increased from 392 in 2003 to 746 in 2005, (average 16 patients per three hour session). The service sees more younger patients and males than the routine clinic, and has a higher chlamydia rate (22.6%). 18% of female attenders wanted contraceptive advice, usually emergency contraception.

This clinic is popular with patients and staff. It has increased capacity and diverted asymptomatic patients from doctor clinics. It provides a less threatening introduction to STI testing as it has become known that invasive testing is not carried out in this clinic.

The absence of a doctor and microscopy facilities means complex or symptomatic patients have to return to the routine clinic. We have made a bid to open a doctor clinic alongside but separate from the nurse clinic to improve the service for these patients.

#### **P42 AN EVALUATION OF EFFECTIVENESS OF NURSE-LED CLINICS FOR ASYMPTOMATIC SCREENING/CONTACT CLINICS**

R. Challenor, E. Henwood, J. Burgess, D. Clare. *GUM Department, Level 05, Derriford Hospital, Plymouth PL6 8DH, UK*

**Aim:** To audit outcomes and patient satisfaction following the implementation of nurse-led asymptomatic screening clinics and contact clinics (following in-house competency based training and assessment for Band 5 nurses and above).

**Methods:** A retrospective audit of all patients attending nurse-led clinics from 01/07/2005 to 30/11/2005 was undertaken. In addition patients were asked for their views of the nurse-led service including the length of wait to appointment and satisfaction with the service.

**Results:** 446 patients were seen in the first five months following implementation. A sexual health screen was performed in 433 (216 females and 217 males). Forty one patients (9.5%) were chlamydia positive by ELISA testing (background clinic rate during audit period was 8.5%). A total of 64 patients (14.7%) had non-chlamydial urethritis or cervicitis or were asymptomatic contacts of chlamydia positive patients. Uptake of HIV testing was 72%. Nurse-led clinic appointments were available within one week (background clinic wait-to-appointment during audit period was two to three weeks).

**Conclusion:** The nurse-led clinics were judged successful in improving access to local GUM services by providing earlier appointments for patients and by allowing doctors to concentrate on more medically complex service provision. Since changing to the new system, nursing and medical staff are satisfied with the nurse-led service. Patient satisfaction is yet to be evaluated.

#### **P43 EVALUATION OF THE NEWLY INTRODUCED NURSE-LED ASYMPTOMATIC CLINICS: HOW SAFE AND EFFICIENT ARE THEY?**

S. Schoeman, E. Morris, R. Bussy, A. Evans, R. Lee. *Centre For Sexual Health, Leeds General Infirmary, Great George Street, Leeds LS1 3EX, UK*

**Introduction:** With the increasing demand on sexual health (SH) services and strategic drivers to extend the roles of sexual health staff our department has recently introduced male asymptomatic nurse-led clinics. Are these clinics safe and efficient?

**Method:** We audited the notes of 100 patients (11%) who had attended the male asymptomatic clinic between October 2004 and September 2005. Patients are booked into these clinics if they report no symptoms to non-clinical reception staff. We looked at the standards of history taking based on draft BASHH guidelines, examination findings, whether appropriate screening was offered, and whether appropriate medical input was sought. Efficiency was assessed on the basis of the amount of medical input required.

**Results:** 39% of patients were symptomatic. 99% of histories taken were in keeping with BASHH standards. 91% had an HIV risk assessment and were offered HIV testing. 75% had appropriate tests offered. In 39% medical input was deemed necessary in the opinion of medical staff—of these 15% received no medical input. 25% required a prescription. Patient Group Directives (PGDs) would have reduced the need for medical input from 39% to 28%.

**Conclusions:** In the majority, these clinics were safely run with excellent history taking, risk assessment, and appropriate testing. A significant proportion of patients self-defining as "asymptomatic" actually had symptoms requiring additional medical input. PGD implementation will only have a limited impact on reducing the medical support. This needs to be considered when planning similar services in both specialist and non-specialist sexual health sites.

#### **P44 IS IT TIME FOR THE VIRTUAL CHAPERONE IN GENITOURINARY MEDICINE CLINICS? THE STAFF OPINION**

R. S. Jones, C. E. Cohen, K. A. McLean, J. M. Pickett, S. Mandalia, S. E. Barton. *West London Centre for Sexual Health, London, UK*

**Background:** The GMC recommends offering chaperones for intimate examinations. The virtual chaperone (VC) is an objective device making audio and visual recordings of patients' consultations and examinations. Information cannot be manipulated and is encrypted for security. It would not replace human chaperones. This study investigates the attitudes of genitourinary medicine (GUM) staff to the VC in an inner city sexual health clinic.

**Methods:** Voluntary, anonymised questionnaires were distributed to an inner city GUM clinic multidisciplinary team.

**Results:** The response rate was 69% (24), comprising 50% doctors, 38% nurses, and 12% health advisers. Almost three quarters of staff (71%) felt unsure or did not support introducing the VC into GUM clinics. Less than half (42%) would feel comfortable with the VC recording during consultations but 75% stated the amount of information they provided would remain unchanged. The majority (71%) felt patients should consent for the VC in writing at each clinic visit, but found the delay this would cause unacceptable. Less than half (42%) were convinced the encryption process would sufficiently protect confidentiality. Two thirds (67%) stated that if they were a patient, they would elect to switch the VC

off altogether. Most respondents (83%) felt the VC protected both staff and patients, but 71% indicated that the Trust would also benefit.

**Conclusion:** Despite its success in other outpatient specialties, GUM staff clearly do not favour the introduction of the VC, in spite of the majority indicating a sense of protection from its presence.

#### P45 IS IT TIME FOR THE VIRTUAL CHAPERONE IN GENITOURINARY MEDICINE CLINICS? THE PATIENT OPINION

R. S. Jones, C. E. Cohen, K. A. McLean, J. M. Pickett, S. Mandalia, S. E. Barton. *West London Centre for Sexual Health, Charing Cross Hospital, Fulham Palace Road, London, UK*

**Background:** The GMC recommends offering chaperones for intimate examinations. The virtual chaperone (VC) is an objective device making audio and visual recordings of patients' consultations and examinations. Information cannot be manipulated and is encrypted for security. It would not replace the human chaperone. This study investigates the attitudes of genitourinary medicine (GUM) patients to the VC in an inner city sexual health clinic.

**Methods:** Voluntary, anonymised questionnaires were distributed to patients attending a GUM clinic.

**Results:** The response rate was 90% (180), with similar proportions of new and follow up patients. Over half of respondents were white, the majority were heterosexual and the modal age group was 20–29 years of age. Only 40% of respondents felt the VC was acceptable in GUM clinics. Two thirds felt unsure or were against the VC recording during consultations, and fewer wished the examination to be recorded. Most would opt to switch off the video entirely. Almost 50% of respondents felt that the VC was designed to protect staff, whereas only 41% thought it would protect patients.

**Conclusion:** Despite its success in other outpatient specialties, GUM patients do not favour the introduction of the VC. The device is intended to provide an objective overview, yet less than 50% of patients felt protected by its presence. Clearly this is a contentious issue, with "invasive", "disrespectful", "loss of privacy", "smacks of Big Brother" being recurrent themes in the patient response section. At present the VC would not be appropriate for use within genitourinary medicine.

#### P46 A STUDY INTO CONSISTENCIES AND INCONSISTENCIES IN THE USE OF KC60 AND LOCAL DIAGNOSING CODES

K. Coyne, C. Cohen, A. McOwan. *Chelsea & Westminster Healthcare NHS Trust, UK*

**Aim:** To study the coding of GUM attendances by doctors across our Trust.

**Method:** Twenty mock cases were designed to cover a spectrum of GUM consultations. Doctors assigned local and KC60 codes for service provision and diagnoses.

**Results:** Thirty two doctors completed the study across three sites. They gave a wide range of responses, often missing codes or adding inappropriate codes. Where the diagnosis was clear, for example, gonorrhoea, 97% of doctors assigned the correct KC60 code. However, the KC60 codes for service provision (S1, S2, P1A, P3, etc) were frequently omitted, and thus represent a significant underestimate of workload. Some local codes were given by as few as 6–28% of clinicians. When they included local codes, they were more likely to omit the KC60 codes.

**Conclusion:** The omission of KC60 codes could have serious implications for GUM clinics when Payment by Results is introduced. The low response rates using our local codes clearly renders these unhelpful. Simplification of our coding procedure is needed to ensure that diagnoses and workload are documented accurately. Otherwise, underreporting by GUM clinics could result in a significant shortfall in funding.

#### P47 WHAT DO PROSPECTIVE PATIENTS WANT FROM A GENITOURINARY MEDICINE SERVICE?

L. H. Fellows, G. Gilleran, J. Ross. *Whitall Street Clinic, Department of Genitourinary Medicine (GUM), Whitall Street, Birmingham B4 6DH, UK*

**Background:** With increasing rates of sexually transmitted infections and attendances at genitourinary medicine (GUM) clinics, there is a need to review how services are delivered. Various initiatives have been suggested, and although these changes allow more patients to be seen, is the quality of service still acceptable? Clinics have often acted as the

patients advocate but not asked what they think. We carried out a community based survey to assess the views of a sample of people from the general public on alternative models of service delivery.

**Methods:** 250 men and 250 women, randomly selected from the general public between the ages of 16 and 25, were interviewed. The acceptability of certain specific interventions were assessed and compared to "standard" practice.

**Analysis:** Preferences for delivery of services and provision of results were ranked and compared using  $\chi^2$  and multivariate analysis was also performed.

**Results:** The majority of those questioned did not like the concept of only being contacted after their initial consultation if their results were positive. This was only slightly more acceptable if waiting times could be reduced as a consequence. Preferences for obtaining results were face to face, by telephone, or by letter. Approximately half did not want to use email, text, or a secure website.

**Conclusions:** In modernising clinic procedures we have made assumptions regarding prospective patient preferences, and this study has shown some surprising and conflicting results. The research findings have the potential to help develop more of a balance between increased efficiency and patient preferences.

#### P48 HOW DO PATIENTS WANT TO BE CONTACTED? IMPLICATIONS FOR ACCESS

S. Bhaduri, C. Gosling. *Arrowside Unit, (Department of Sexual Health), South Worcestershire Primary Care Trust, UK*

**Introduction:** Genitourinary medicine (GUM) services are currently considering methods of improving access and increasing capacity. One method may be selective follow up either via primary care or mobile phone as opposed physical return to the GU clinic. Are these measures acceptable to GUM attendees?

**Methods:** Patients attending Worcestershire Sexual Health Service are asked to complete a form specifically asking if they can be contacted either at home by letter, mobile, or at work or via the GP. 300 case notes were analysed retrospectively with respect to age and contact preference.

**Results:** 171/300 (57%) ( $p < 0.001$ ) of patients were happy for their GP to be contacted although age specific data showed significance only in patients aged 15–19 (36/54, 66%) compared to other ranges. 163/300 (54%) were happy to be contacted by home telephone (not significant), however 40/54 74% ( $p < 0.001$ ) aged between 15–19 did not want to be contacted this way. 144/300 (48%) elected to be contacted by letter at home especially those aged 15 and 19 (34/54, 62%, ( $p < 0.01$ )) but not those aged 20 and 24 (42/64, 66%  $p < 0.001$ ). 211/300 (70%) thought contact via mobile phone was acceptable ( $p < 0.001$ ) and 291/300 (97%) declined to be contacted at work ( $p < 0.001$ ).

**Conclusion:** A significant number of patients (57%) considered contact via primary care was acceptable, should permission be granted. The majority of patients were happy to be contacted via mobile phone (70%). The data therefore suggest potential in decreasing clinic returns.

#### P49 IS TELEPHONE FOLLOW UP AN EFFECTIVE USE OF RESOURCES FOR PATIENTS WITH TREATED GENITAL INFECTION?

K. Gundugola, M. Ward, E. M. Carlin. *Department of Genitourinary Medicine, King's Mill Hospital, Sherwood Forest Hospitals NHS Trust, Nottinghamshire, UK*

**Background:** To increase new patient access some genitourinary medicine (GUM) clinics use telephone follow up for patients following treatment of infection.

**Aim:** To assess whether telephone follow up is an effective use of resources.

**Method:** A six month prospective study was performed in a GUM clinic using a proforma to capture data.

Abstract P49, table 1

Infection	Telephone follow up	Telephoned as planned	In-person follow up	Attended as planned
CT 181	133	30 (23%)	48	33 (69%)
GC 31	20	6 (30%)	11	8 (73%)
NGU 157	144	52 (36%)	13	9 (69%)



Abstract P49, table 2

Infection	Treatment compliance		Re-infection risk	
	Contacted/seen study	Intention to	Contacted/seen study	Intention to
CT	145 (92%)	145 (80%)	9 (6%)	9 (5%)
GC	24 (100%)	24 (77%)	1 (5%)	1 (3%)
NGU	140 (91%)	140 (89%)	4 (3%)	4 (3%)

**Results:** 369 infections were identified, 158 *Chlamydia trachomatis* (CT), 31 gonorrhoea (GC), 157 non-gonococcal urethritis (NGU). 23 NGU were CT positive and were subsequently included in the CT analysis. Telephone follow up was planned for 295 (80%), the rest were asked to return for in-person follow up. The response is shown in table 1.

Health advisors contacted defaulters, 1–6 telephone attempts and/or 1–4 letters per patient, reaching a further 178 patients. Compliance and re-infection risk is shown in table 2. Additional contact information was obtained in 18 cases.

**Conclusion:** There were high rates of compliance and low re-infection risks. Follow up and recall involved high health advisor workload for limited benefit. There was significantly less in-person default but this should only be used if clinically required. Telephone follow up and recall appears an inefficient use of resources.

### P50 CLOSING THE CLINICAL CONSULTATION: SAVING TIME AND MONEY IN RESULT PROVISION

A. Menon-Johansson, F. McNaught, A. Sullivan. *The John Hunter Clinic for Sexual Health, Chelsea & Westminster Healthcare NHS Trust, London, UK*

**Background:** A Text Message Result Service (TMRS) was introduced in March 2004. Prior to this, results could only be obtained by telephone or by returning to the clinic.

**Aim:** To determine the time and economic impact of introducing this service.

**Methods:** The study periods were August over three years (2003–05). The number and mode of all results given were collected. Time to provide results via clinic re-attendance, results phone line, and text message was estimated to be 12, 4, and 1.5 minutes respectively. Cost to provide results was based on a salary of £13/hour. The total number of sexual health screens was calculated from the sum of KC60 codes, S1 and S2.

**Results:** See table.

**Conclusion:** The TMRS has transformed the provision of results. Forty per cent less time and money is now required to more effectively communicate with our patients. These benefits exist despite some anxious patients using two or more modes to access this information.

### P51 IS TEXTING AN EFFECTIVE STRATEGY FOR PROVIDING RESULTS?

K. Prime, K. O'Connor, D. Thirlby, D. Jones, P. Lister. *Queen Mary's Hospital, St George's Healthcare trust, London; South West London HIV & GUM Clinical Services Network (SWAGNET)*

**Background:** To evaluate the use of a results texting service in asymptomatic female attendees at the Roehampton clinic (genitourinary medicine). Sexually transmitted infection (STI) contacts, patients <15 years, symptomatic patients, and those with an STI are currently excluded from the texting service.

**Methods:** Retrospective case note review of 200 consecutive new or rebook asymptomatic female attendees.

**Results:** 11/200 asymptomatic females (median age 25 years, range 18–47 years) had a subsequent infection diagnosed (chlamydia n=8, gonorrhoea n=2, UTI n=1). All were successfully recalled for treatment. 28/200 asymptomatic females were contacts (NSU n=19, chlamydia n=7, gonorrhoea n=2). None subsequently had positive STI results. 72/200 booked a text result with 66/72 actually being texted. 5/72 were telephoned with a positive STI result. 1/72 telephoned the clinic as a text had not been received. 108/200 arranged to telephone for results with 94/108 actually telephoning. The reasons for telephone review were appropriate in 61/108 including: contact of a STI (n=28), patient anxiety/request (n=16), higher risk group for HIV (n=9), pregnancy (n=2), warts (n=2), candidiasis (n=2). 17/200 were offered a health adviser appointment for results of whom 11 were in a higher risk group for HIV. Only 3/200 were booked to see a doctor for results.

**Conclusion:** Results texting is a reliable service reducing the need for patient follow up in clinic. All asymptomatic females with STIs subsequently diagnosed were successfully recalled and treated. 33% of asymptomatic female patients were texted with results. Extending the results texting service to asymptomatic STI contacts is contentious but should be considered.

### P52 TEXT MESSAGE SERVICES: THE SEXUAL HEALTH PATIENT'S PERSPECTIVE

C. A. Bowman, P. Bennett, T. Kyi. *Department of Genitourinary Medicine, Rotherham District General Hospital NHS Foundation Trust*

**Introduction:** Increasing demand on genitourinary medicine services (GUM) and 48 hours appointment targets have encouraged the development of appointment saving initiatives. Text messaging appointment reminders reduces DNA rates. Texting negative STI results reduces follow up visits. We introduced text messaging in May 2004 and present a review of patient satisfaction with this system.

**Methods:** A short self-administered patient questionnaire was given to 100 patients (25 new male, 25 new female, 25 follow up males, and 25 follow up females) by receptionists at booking. New patients would have experienced a texted appointment reminder only at this stage. Five key questions were asked:

1. Do you feel the text messaging service is a good idea?
2. Did you find this service more convenient for you?
3. Did you find the content of the text message clear and understandable?
4. Did you feel that your confidentiality was upheld within the text message?
5. Would you be happy to use our texting service in the future?

**Results:** 95% of those questioned liked the service. 82% found it a convenient method of receiving reminders and results. 84% would be happy to use the texting service again. 73% found the content of the text message clear. 64% were happy with confidentiality aspects

**Discussion:** Text messaging reduces follow ups and DNAs. However, some patients found the messages difficult to understand or were anxious about confidentiality. Subsequent improvements are discussed.

### P53 THE COMPUTER FACILITATED TELEPHONE ACCESS SYSTEM: A NOVEL METHOD FOR PATIENT RESULTS RETRIEVAL

N. M. Steedman, C. Thompson. *Department of Genitourinary Medicine, Royal Infirmary of Edinburgh, Lauriston Building, Lauriston Place, Edinburgh EH3 9HA, UK*

The recommended standards for sexual health services as outlined by the Medical Foundation for AIDS and Sexual Health state that patients who

Abstract P50

Year, (August)	Sexual health screen number (=KC60 codes S1+S2)	Number of results and staff time required (number of results hours taken)				Proportion of total results by text (%)	Monthly cost for result service (£)
		Text	Phone	In person	Total		
2003	820	0	268	347*	615*	0	1135*
		0.0	17.9	69.4	87.3		
2004	889	285	365	191	841	32	905
		7.1	24.3	38.2	69.6		
2005	894	702	200	106	1008	78	677
		17.6	13.3	21.2	52.1		

\*The calculations for 2003 are made on the assumption that 75% of patients obtained their results.

may have been at risk of STIs should receive information on the infections they are being tested for, and know how and when they can receive their results.<sup>1</sup> In practice, the conveyance of such results to an ever expanding population of attendees at genitourinary medicine clinics imposes a considerable burden on already busy hospital departments.

In August 2005 we installed a 24 hour computer facilitated telephone results access system in our department. This initially provided a third alternative to either a posted results letter, or a letter available for collection from the department. An audit conducted for the month of September 2005 revealed that the majority of patients chose to access their results using the new telephone system, and that there were no complaints regarding the system. Therefore from January 2006 we adopted the computer facilitated telephone results access system as our principal method of conveying results to patients.

Here we present data regarding the installation and running of the system, and uptake rates by patients to date. We propose that this novel method of results retrieval provides an efficient, cost effective solution that also demonstrates a high level of patient acceptability.

1. March 2005, Med FASH/Department of Health.

#### **P54 NO NEWS IS GOOD NEWS ... HOW RELIABLE?**

S. Terzoudi, C. Elliot, N. Desmond. *The Garden Clinic, Upton Hospital, Slough, UK*

**Background:** Previously patients who underwent tests for sexually transmitted infections (STIs) were told to telephone two weeks later for their results. Difficulties with telephone access and increasing health adviser workload led us to develop a new results protocol whereby patients were told "no news is good news". Only those with a positive, equivocal, or invalid result would be informed by the health adviser within three weeks of their screen.

**Aim:** To ensure that all positive results for bacterial STIs had been actioned by the health adviser team within three weeks.

**Method:** A retrospective study of all positive chlamydia, gonorrhoea, and syphilis results from 1 April to 31 September 2005 were identified electronically by the microbiology laboratory at and compared to the health advisers' action sheet documenting the outcome of positive results received as paper copies.

**Results:** 352 positive results (11063 tests taken): all of these (that is, 100%) were actioned by the Health Advisers within three weeks. 349 (91.1%) were treated according to the BASHH guidelines. Three positive chlamydia patients who did not attend were appropriately followed up.

**Comments:** This method of only actioning positive results is reliable ... so no news really is good news. However correct patient contact details are essential—ideally two means of contact and vigilant verification that they are recorded correctly.

#### **P55 PARTNER NOTIFICATION BY TELEPHONE: COSTS AND OUTCOMES**

G. Bell. *Genitourinary Medicine, Royal Hallamshire Hospital, Sheffield, UK*

**Background:** Managing partner notification (PN) for patients diagnosed outside GUM presents a challenge, since there are insufficient trained interviewers in community settings to discuss PN face to face, at the time of diagnosis. This study therefore aims to assess the feasibility and effectiveness of PN specialists (health advisers) managing PN by telephone, where it may be more difficult to ensure privacy and develop sufficient rapport to engage cooperation. Costs are included.

**Methods:** The outcomes of PN for chlamydia were compared for two groups Sept 04 to May 05. Group A had a face to face interview following diagnosis by GUM. Group B were interviewed by telephone following diagnosis by the local Chlamydia Screening Programme (CSP). Samples were matched for age group (<25), number (281), and gender mix (248 females). GUM health advisers undertook all interviews. For group B, time taken for interviews, provider referral and verification was recorded and costed.

**Results:** The number of contacts per index case who could be verified as having attended was comparable: 0.82 for telephone and 0.85 for face to face interviews. These both exceed the national standard of 0.6 contacts per case. Time spent on telephone PN averaged one hour per case, at a cost of £17.50.

**Conclusion:** PN interviews by telephone can be as effective as face to face interviews when undertaken by experienced staff. The costs are relatively modest if no prior training is required and facilities can be shared.

#### **P56 "EFFORTLESS" IMPROVEMENT IN PROPORTION OF SEXUAL CONTACTS THAT RECEIVE APPROPRIATE TESTING AND TREATMENT**

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**Background:** Despite record numbers attending GUM there has been little impact on the rising epidemic of infection.

**Introduction:** The traditional partner notification slips fail to give the recipient or the clinician, outside GUM, the information they need to access or deliver appropriate care. Our Centre has developed and piloted a "partner notification letter" (PNL).

The PNL benefits: (1) the sexual contact, it names the infection and details how to access further information. It informs why and what further care they need and provides local and national choices as to where care can be accessed. The PNL highlights that if they do have the infection, they will need to inform their sexual contacts too. (2) The clinician to whom the PNL is taken receives the current BASHH contact testing and treatment guidelines for the infection. If infection is confirmed it informs them of the duration of the look back period for ongoing partner notification. (3) The centre issuing the PNL asks the clinician directly for a "return" to make partner treatment verification effortless.

**Method:** We will retrospectively compare the proportion of sexual contacts that obtain appropriate care before and after the introduction of our PNL. So far we have looked at only two months of data.

**Result:** The proportion of sexual contacts obtaining appropriate care has risen from 40% prior to the introduction of the PNL to 61% after.

**Conclusion:** This letter has increased by 50% the number of sexual contacts obtaining appropriate care and has also improved verification rates.

#### **P57 INCIDENCE OF SEXUALLY TRANSMITTED INFECTIONS AT HMP PRISONS IN NOTTINGHAM**

C. Gan, I. H. Ahmed. *GU Medicine, Nottingham City Hospital, UK*

**Background:** Several studies have shown significant incidence of sexually transmitted infections (STIs) amongst the UK prison population. There is currently a fortnightly provision of STI/blood borne infection service in the two local prisons provided by a GU Medicine consultant.

**Aim:** To determine the incidence of STIs in the Nottingham prisons. To explore reasons behind differences between the two.

**Method:** Case notes audit between January 2005 and September 2005 was conducted. 124 patients (83 GUM, 38 blood borne) were seen. 42 patients were not seen because they had been transferred (8), had prison visits (11), or refused to attend (23). A total of 76 notes on GUM attendance were retrieved (Nottingham (63), Lowdham (13)). Data on demographics such as age, ethnicity, past STI, sexual orientation, diagnosis, and treatment regimes audited against BASHH guidelines.

**Findings:** The demographics for inmates in both prisons were similar. 27/63 (42.9%) cases of STI were identified from the Nottingham Prison (31.7% had chlamydia and 6.3% had gonorrhoea). 5/13 (38.5%) cases of STI were recorded from Lowdham prison. Two (15.4%) had genital warts, two (15.4%) patients had HSV infection, and one patient (7.7%) was diagnosed with syphilis.

**Conclusion:** There is a high incidence of STIs among the prison population in both establishments. Inmates at the remand centre were more likely to have acute infections compared with the long stay prison. PCR test on urine to be incorporated into mandatory urine drug test at reception. Weekly GU service would be recommended for high turnover remand establishments.

#### **P58 EXPERIENCE OF SETTING UP A GENITOURINARY MEDICINE INREACH CLINIC IN A MALE PRISON**

I. Boss, L. Law, J. Sherrard. *Department of GUM, Radcliffe Infirmary, Oxford, UK*

A fortnightly inreach genitourinary medicine (GUM) service to a medium security male prison has been provided since April 2004. Patients are seen by referral from the prison GP, or by an individual's request. Problems have arisen due to a lack of space and time—the health adviser and doctor have to share a room. The prisoners have to leave Health Care by 11:30, so if one inmate has complicated issues it can result in these not being dealt with, or patients not being seen as there is no flexibility.

Unexpectedly there has been a high DNA rate which is due to prisoners moving to another prisons since a request to be seen was made, court attendances and legal visits. Additionally some men choose not to come when sent for on the day. A few men who attend do so

mistakenly thinking that GUM is the dentist. This is particularly a problem where English is not the first language.

The attendance of prisoners at the GUM service is noted in their prison health record, with relevant information, such as referral for management of hepatitis C. Of 219 men seen in the first year 55% had a GUM screen. The most common infections were chlamydia 10.5%, warts 12.1%, and HCV 9%.

The clinic has been well supported by patients and prison staff. High rates of infections are being detected and managed. The men have been happy to be screened and despite initial concerns all are happy to provide urine specimens for chlamydia screening.

## P59 INCREASING DEMAND FOR CLINICAL SERVICES FOR SEX WORKERS

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**Background:** The provision of sexual health care and health promotion for sex workers is a key part of any HIV/STI control programme. There are increasing numbers of women selling sex in London, but few specialised services.

**Methods:** Review of routine activity data.

**Results:** See table. From 1998 to 2005 there has been a steady increase in clinic attendances (2.2-fold), with more individuals (2.3-fold) and new patients (3.1-fold).

The increased activity has been achieved with only a 50% increase in clinic sessions (4-6 per week), together with a more efficient use of resources: better use of nursing team, provision of results/follow up by phone or via drop-in, reduced paperwork. However, we still fail to meet demand: the wait for a routine appointment is approximately four weeks.

**Discussion:** The increased activity of this specialist clinic shows that a voluntary, confidential service can be effective in reaching sex workers. However, despite increased efficiency and capacity, waiting times for appointments are unacceptably long. This will lead to more demand on non-specialist services where wider support and health promotion is not available. An expansion of capacity is required across London to improve access, and to ensure that the sex industry does not become part of the problem of increasing STI and HIV.

## P60 INNOVATIVE SAUNA OUTREACH OFFERING NON-INVASIVE SEXUAL HEALTH SCREENING TO COMMERCIAL SEX WORKERS: COSTS AND OUTCOMES

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**Background:** Commercial sex workers (CSWs) are at high risk of STI and are often hard to reach. Barriers to service use include concerns around stigma, a dislike of invasive screening methods, and current waiting lists in genitourinary medicine (GUM). We are piloting the provision of non-invasive screening during outreach in a local sauna for 12 months to assess feasibility, outcomes, acceptability, and costs.

**Methods:** Two health advisers visit the sauna monthly. Non-invasive STI tests include: self-taken vaginal swabs, urines and throat swabs for gonorrhoea and chlamydia; saliva tests for syphilis, HIV, hepatitis B and C. Women reporting abdominal pain or genital lesions were referred to GUM. Costs include staff time, travel, tests, and treatment.

**Results:** Uptake of screening has been good in the first six months: 23 interactions resulted in 16 screens for 10 different women. Of these, three had never been screened before and five had not been screened for over six months. No STIs have been found so far, although five cases of bacterial vaginosis and three cases of *Candida albicans* have been treated. The average cost per screen is £93.

**Conclusion:** Non-invasive screening during sauna outreach is acceptable to CSWs and can improve access to care. The average cost of £93

is less than the national new patient tariff of £127. Low numbers of screen per session (3) are required to make the service cost neutral, even with corporate overheads deduction. The absence of STI so far in this high risk population is reassuring.

## P61 MANAGING SEXUAL ASSAULT VICTIMS: ARE WE GETTING IT RIGHT?

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**Background:** Post-traumatic stress disorders are common following sexual assault. In addition to screening and managing sexually transmitted infections (STIs), offering counselling is a vital part of providing holistic care to these victims.

**Aim:** We audited the management of sexual assault victims attending this inner city GU Medicine Clinic.

**Methods:** Cases were identified from a separate case register for sexual assault victims and notes have been reviewed from May 2000 to June 2005.

**Results:** One hundred and one individuals who identified themselves as victims of sexual assault attended our clinic. Ninety four (93%) were female, 86.1% were of white ethnic origin. The median age was 18 (range 5-52) years. Forty (39.6%) individuals were referred by other agencies. Assaultant was known to 52 (51.4%) victims. Thirty (29.9%) individuals presented within seven days of the assault and only 14 (46.6%) came for follow up. All had screening for STI. Seventeen had STI and all were treated. Eight were at risk of pregnancy and emergency contraception was offered to six (75%) cases. Counselling was offered to 55 (54.9%) cases. Compared to females, less male victims received counselling (57.4% v 14.2%, p=0.02). Assault was the first sexual experience in 26 (25.8%) cases and only 14 (53.8%) of them received counselling.

**Conclusion:** This audit highlights that GU clinics are focussed more on the infection screening of victims of sexual assault. The clinicians should ensure that the victim sees the Health Adviser who identifies the need for emotional support and provides information about local victim support organisations.

## P62 CREATION OF A VIRTUAL CORRIDOR TO FACILITATE REFERRALS BETWEEN CONTRACEPTIVE SERVICES AND THE GENITOURINARY MEDICINE DEPARTMENT

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**Background:** In locations where the genitourinary medicine (GUM) department and Contraception and Sexual Health (CASH) are on separate sites several studies have shown a low rate of attendance of patients referred between the sites. We developed a coupon system to allow patients referred from one site to be seen without a wait in the open access clinic at the other site. Data from the first five months were collected.

**Methods and Results:** Fifty nine patients were referred from CASH to GUM during this time. Of these 54 (91.5%) attended the GUM department. The majority (67%) were referred with symptoms suggestive of an infection, while other reasons for referral included contacts of infections, high risk behaviour, and following a sexual assault. 40% of patients were seen within 30 minutes of their referral. Of patients referred from GUM to CASH 12/18 (67%) attended the clinic. 63% were seen within 30 minutes of their referral. Seven patients were referred for consideration of IUCD insertion for emergency contraception, but only four attended. Similarly of the four patients referred who were not using any contraception, only one attended.

**Conclusions:** We believe the coupon system helped increase attendance rates of patients referred between the two clinics, especially by eliminating the wait in the second clinic. The lower rate of attendance in those referred to the contraception services is a cause of concern.

Abstract P59 PSP clinic attendances 1998-2005

	98-99	99-00	00-01	01-02	02-03	03-04	04-05
New patients	80	103	111	116	125	183	247
Different individuals	500	525	563	636	679	845	1157
All attendances	566	591	639	752	815	958	1241



### P63 ONE STOP SEXUAL HEALTH SHOPS FOR YOUNG PEOPLE: HOW WELL ARE WE DOING?

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**Background:** The National Sexual Health Strategy advocates one stop sexual health shops for adolescents as a way of reducing both STIs and pregnancy rates in teenagers. We have recently set up a young peoples clinic (YPC) for those aged <21 years, which runs once weekly, is open access, and is staffed by a doctor, two nurses, and a health advisor, all of whom are family planning trained. We present the findings from the first four months of this new service.

**Results:** Over the first four months 195 young people made 233 visits to the YPC. 10 were under 16 years. 11 were aged 21–25 years. 77% were female. 92% had an STI screen of whom 38% had an STI and a further 7% were treated as contacts. 74% had an HIV test, all of which were negative. 71% of female patients were already using regular contraception and in a further 7% contraception was either discussed or started. However, in 22% contraception was not discussed. Only 1/10 under 16 year olds was referred to a health advisor.

**Conclusion:** The prevalence of STIs in this population is high. Despite the fact that all staff within the clinic are Family Planning trained, contraceptive issues were not adequately addressed.

### P64 IS THE USE OF A PROFORMA HELPFUL IN IDENTIFYING RISK OF HARM IN UNDER 18 YEAR OLDS ATTENDING A GENITOURINARY CLINIC?

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**Background:** In 2004 a proforma was introduced with the aim of identifying risk and vulnerability factors in attendees under the age of 18. The proforma included assessment of Fraser competency in under 16 year olds, and additional information including current or past non-consensual intercourse, abuse, age of sexual partner, mental health, and social problems.

**Methods:** One in four attendees under the age of 18 between 1 December 2004 and 28 February 2005 were randomly selected for a retrospective case notes review (n=83).

**Results:** A proforma was completed for 76% of under 18 year olds attending. Completion rates were lower for 16 and 17 year olds compared to those under 16 (76% and 67% v 100%). Fraser competency was assessed in 100% of under 16 year olds. Sexarche was 15 years for 31% and 14 years for 28% of the sample. Average number of lifetime partners was three. Previous non-consensual intercourse was revealed by 6% of patients, and 2% had been paid for sex. Of the sample, 7% revealed previous or current abuse (sexual or physical). Current or past mental health problems were identified in 31% of the sample population. 20% of patients had current or past involvement with other agencies—for example, social services. Identification of child protection issues led to onward referral in several cases.

**Conclusion:** Within this sample the use of a proforma revealed a significant level of vulnerability and risk in under 18 year olds which may otherwise not have been identified and addressed.

### P65 ARE THE SEXUAL HEALTH NEEDS OF PATIENTS OVER THE AGE OF 45 DIFFERENT FROM YOUNGER PATIENTS?

S. Andrews, S. Noble, M. Pakianathan. *Department of Genitourinary Medicine, St George's Hospital, London, UK*

**Background:** There is an increasing drive for sexual healthcare provision to be tailored to the needs of young people. In our centre, 5% of those seeking care are aged >45 years. There are few data available on the sexual health needs of this patient group.

**Methods:** A retrospective case notes review comparing new/rebooked patients >45 years attending an inner London GUM clinic to a random sample of patients <45 years attending over a month period (September 2005). Sexual activity, sexual risk taking behaviour, and prevalence of sexually transmitted infections (STI) were compared between the two groups. Chi square tests were performed to investigate differences.

**Results:** The case notes of 98/107 (92%) of the eligible study population and 98 in the control group were available for review. There was no significant difference in gender, sexual orientation or ethnicity between the groups. People >45 were more likely to present with symptoms (73% v 48%, p<0.025), less likely to have had a STI in the past (21% v 40%, p<0.001), and as likely to be diagnosed with a STI (24% v 28%, p=NS). There were no differences between the groups when comparing

the proportion that had started new relationships or had had casual relationships.

**Conclusions:** In this study clinic attendees over 45 reported similar sexual risk taking behaviour to younger patients. However they are more likely to present with symptoms and less likely to have had a previous STI. These findings indicate that consideration must be given to the needs of older patients while planning provision of GU services.

### P66 IMPROVEMENT IN SCREENING FOR SEXUALLY TRANSMITTED INFECTIONS IN HIV POSITIVE PATIENTS

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**Aim:** UK and local guidelines recommend that all newly diagnosed HIV positive patients undergo a sexual health assessment at first presentation and then at 6–12 monthly intervals. In July 2004 an audit project established the need for a specific sexual health clinic for HIV positive patients; female and male clinics were set up accordingly. The audit was repeated 18 months later to assess changes in uptake of STI screening, and address compliance with guidelines.

**Methods:** A standard proforma was used to collect data by case note review from 100 consecutive patients attending general HIV clinics in July 2004 and January 2006.

**Results:** Patient demographics for 2006 data were as follows: 48% female, 63% heterosexual, 33% homosexual men, 54% black African, 33% white. The percentage of patients undergoing STI screening at HIV diagnosis increased from 37% in 2004 to 52% in 2006. 23/52 (44%) of patients screened at baseline from 2006 data were found to have a STI. The percentage of patients having a sexual health discussion in the last 12 months increased from 39% in 2004 to 70% in 2006. 13/46 (28%) of patients screened in 2006 tested positive for an STI. Annual cervical cytology in women increased from 44% in 2004 to 64% in 2006.

**Conclusion:** Increased rates of STI screening indicate that a specific STI clinic for HIV patients is feasible and acceptable. High rates of STIs highlight the need for regular screening. In order to meet guideline targets, further work is needed to establish barriers to screening.

### P67 NURSE-LED "SEXUAL HEALTH SCREENING" AT HIV CLINIC

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**Aim:** To assess the uptake and benefits of offering a sexual health screen to patients attending the HIV clinic.

**Methods:** Patients attending the HIV clinic for routine care were offered the option of a sexual health screen during visits between January and December 2004. This service was Nurse-led and included a sexual history and screen for common sexual infections (STIs) including chlamydia, gonorrhoea, and syphilis in both sexes, *Trichomonas vaginalis* and *Cervicitis* in women and tests for non-gonococcal urethritis (NGU) in men.

**Results:** A total of 42 patients (27 male, 15 female) were offered the screen. 26 (69%) agreed to have a screen, while 13 (31%) declined. Of those who declined, eight were not sexually active and four had a regular long term partner. Of the patients screened, one male (3.4%) was diagnosed with NGU, three (10.3%) (two males, one pregnant female) were diagnosed with chlamydia and two males (6.8%) were diagnosed with gonorrhoea. Two males (6.8%) were diagnosed with primary/secondary syphilis and previously treated syphilis was confirmed in two other males.

**Conclusions:** Routine offer of sexual health screening at the HIV clinic was acceptable to most patients. STIs were diagnosed in a significant proportion of patients screened, highlighting the benefit of such a one-stop service.

### P68 DEVELOPING A "ONE STOP" SERVICE FOR HIV POSITIVE PREGNANT WOMEN

R. McCarthie, E. Carlin. *Department of Genitourinary Medicine, Nottingham City Hospital, Nottingham, UK*

The numbers of HIV positive pregnant women seen within our busy Genitourinary Medicine clinic, based in a teaching hospital, has increased exponentially in recent years with 20 births recorded in 2004 and 2005 alone. Aware of increasing service pressure we sought

to provide an efficient HIV pregnancy care pathway to ensure optimum management of the women's pregnancy and HIV, better patient satisfaction, and enhanced higher specialist training.

The key to achieving this has been the development of a joint "Positive Care Clinic" within the existing antenatal clinic structure. This allows all members of the multidisciplinary team including obstetrician, HIV physician, paediatrician, midwife, pharmacist, and social worker to input into the patient's care at a single visit. The number of patient visits has been reduced, as has the number of duplicated investigations. Improved communication means that less written correspondence is required but management plans are clearer and open to joint review. It has also proved an excellent training facility.

The clinic has been supported by the virologists, who have enabled laboratory prioritisation of samples from the "Positive Care Clinic" to provide up-to-date results that may alter care plans.

Joint working to develop unified documentation and proformas, process mapping, and to adapt the service in response to user needs has been essential.

The service has been very successful in terms of patient satisfaction and pregnancy outcome. These details and further information on the formation of the service, operational management, and documentation will be presented.

#### P69 KNOW4SURE: WHO COMES TO A RAPID HIV TESTING OUTREACH CLINIC AND WHY?

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**Background:** Know4Sure is a rapid near patient HIV testing community outreach clinic, established for members of BME communities. It is a weekly, walk-in evening clinic.

**Methods:** As part of a wider UK study, a questionnaire was given to all consecutive attenders between March and December 2005 to establish their demographic profile, sexual risk and HIV testing behaviours and reasons for using the service.

**Results:** 508 HIV tests were performed and 448 clients completed the questionnaire (88.2% response rate). Fifteen tested positive for HIV (3.0%). 73.2% were male of whom 57.7% were MSM. The mean age was 31 years (range 16–79). Overall 31.8% were from BME communities including 12.7% who were Black African. 26.2% had never had a STI screen, and 31.8% had never previously tested for HIV. Those who had never tested had significantly fewer sexual partners in the last year. The most commonly cited reason for never having tested was "I have been too afraid of the result being HIV positive" (33.6%). 6.2% (8/129) of those that had never tested believed that they were positive and six of these were correct.

68.2% had previously tested for HIV, (median test number 2, range 1–15).

#### P70 AN HIV POINT OF CARE TESTING SERVICE IN PRIMARY CARE IN LAMBETH

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**Introduction:** Testing for HIV in primary care is recommended. A pilot weekly walk-in HIV point of care testing (POCT) clinic was established in

an inner London general practice to promote testing in high risk individuals particularly from African communities. The Abbott Determine HIV 1/2 antibody assay is used to test finger prick samples and all positive results undergo confirmatory testing. Staff training and internal quality control has been established and the service is participating in the UK National External Quality Assessment Service for Microbiology.

**Methods:** Retrospective case note review.

**Results:** See table. 163 patients were seen between 23 February and 14 December 2005. Of 172 HIV tests performed three were positive, all of which were confirmed. The prevalence of HIV was 1.8%.

**Conclusions:** HIV POCT is feasible in general practice providing increased choice and opportunity for testing hard to reach at risk groups, especially from ethnic minority communities. Further evaluation is underway to assess its acceptability and how this can be maximised.

#### P71 HOW USEFUL ARE FOLLOW UP CLINICS FOR RECIPIENTS OF POST-EXPOSURE PROPHYLAXIS FOLLOWING SEXUAL EXPOSURE?

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**Objective:** An audit to assess the effectiveness of a new follow up clinic for recipients of post-exposure prophylaxis following sexual exposure (PEPSE).

**Methods:** Case note review of PEPSE recipients who attended a new follow up clinic in South London between 25 February 2005 and 1 October 2005. Management was audited against recent draft BASHH PEPSE guidelines and compared to an audit performed before the new clinic opened in Feb 2005.

**Results:** Thirty four patients received PEPSE. These were predominantly white (79%), male (97%), homosexual (91%), of median age 32 years and given PEPSE predominantly after receptive anal sex (50%). 74% (25/34) of PEPSE prescriptions were given in accordance with BASHH recommended indications (previous audit 79%, BASHH target of 90% unmet). 94% of patients received PEPSE within 72 hours of risk exposure (previous audit 97%, BASHH target of 90% met). 76% (26/34) of patients completed therapy (previous audit 53%, BASHH target of 75% achieved). 62% (21/34) of patients tested for HIV at three months follow up (previous audit 45%) and 42% (8/19) tested at six months (previous audit 12%, BASHH target of 75% unmet). 94% (32/34) of patients received a recommended combination (previous audit 91%). To our knowledge no patients have seroconverted to date.

**Conclusion:** Following the introduction of a new follow up clinic that places emphasis on adherence support and recall of clinic absconders, we have now achieved the BASHH target for completing PEPSE and have significantly improved the HIV testing rates at three and six-months. Despite this, we have yet to meet the six month follow up BASHH HIV testing target.

#### P72 REGIONAL REAUDIT OF NONOPEP PRESCRIBING

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**Introduction:** This audit was originally performed in our region five years ago. With the development of national guidance about the prescription of NONOPEP it is timely to see how attitudes, experience, and practice has changed.

**Methods:** Questionnaires were sent out to individual members of the regional audit group requesting information about NONOPEP prescribing in the past two years. Opinions were sought on whether NONOPEP should be recommended in different scenarios and then compared to five years ago.

**Results:** The approximate number of prescriptions for NONOPEP in a two year period has risen considerably from 10 to 18 with a higher number of physicians prescribing (from 5 to 10). There was greater agreement amongst clinicians in 2005 that the maximum time duration post exposure to treatment should not exceed 72 hours. Most also agreed the preferred regime would be Combivir and Nelfinavir (14/17 respondents). In 2000, 13 out of 19 documented PEP discussion with serodiscordant couples and seven supported the provision of PEP treatment packs which was similar in 2005 (13/17 and 11/17 respectively).

**Conclusions:** In 2005 all clinicians agreed that NONOPEP would be appropriate where the source patient was HIV+ in all scenarios listed which included anal and vaginal intercourse as well as parenteral transmission. This differs markedly from 2000 where there was considerable uncertainty in most scenarios. Further opinions were

#### Abstract 70

	Male (n=114)	Female (n=49)	Total (n=163)
Median age (range)	29 (18–49)	27 (19–48)	28 (18–49)
Ethnic group			
White	69 (60.5%)	15 (30.7%)	84 (51.5%)
Black African	13 (11.4%)	9 (18.3%)	22 (13.5%)
Black Caribbean	3 (2.6%)	5 (10.2%)	8 (4.9%)
Black other	8 (7.1%)	5 (10.2%)	13 (7.9%)
Other	14 (12.3%)	6 (12.3%)	20 (12.4%)
Not known	7 (6.1%)	9 (18.3%)	16 (9.8%)
Risk behaviour			
Homosexual	41 (35.9%)	1 (2.1%)	42 (25.7%)
Heterosexual	72 (63.2%)	40 (81.6%)	112 (68.7%)
Not known	1 (0.9%)	8 (16.3%)	9 (5.6%)

gathered on the prescription of PEP where the HIV status of the source patient was not known and these findings will be presented.

### P73 PERSISTENTLY UNDETECTABLE HIV VIRAL LOAD 14 MONTHS AFTER STRUCTURED TREATMENT INTERRUPTION

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**Summary:** A 58 year old man on antiretroviral therapy for chronic HIV infection continues to have an undetectable viral load 14 months after stopping treatment.

**Discussion:** There have been a handful of cases of persistent low level/undetectable viraemia post structured treatment interruption reported in the worldwide literature. We report a further case.

**Case history:** This homosexual male was diagnosed with HIV infection in July 1999 when he complained of lassitude and weight loss of 10 kilos. His last HIV test was negative in 1990 and he denied unprotected anal sex in the six months before his diagnosis. Baseline CD<sub>4</sub> was 700 and viral load greater than 100 000 copies. He was commenced on combivir and nelfinavir shortly after presentation as he was symptomatic with diarrhoea and lethargy and then changed to combivir and nevirapine as he preferred the twice daily regime. In June 2004 his antiretroviral therapy was stopped in line with the latest guidance from BHIVA. 14 months later he still has an undetectable viral load and CD<sub>4</sub> greater than 1000.

The following tests are being performed to further elucidate his specific immune response to HIV: lymphocyte subsets, antigen specific CD4 cells using HLA class II tetramers, IgA HIV specific antibody response. The results will be discussed in detail.

### P74 UNDETECTABLE HIV VIRAL LOAD AT PRESENTATION OF PREGNANCY: TWO RECENT CASES

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**Case histories:** Patient 1 was a Zimbabwean diagnosed with HIV infection at our clinic when she was 10 weeks pregnant. Patient 2, born in Ghana, was diagnosed with HIV antenatally and referred from another UK region at 17 weeks' gestation. Both had confirmatory tests performed for HIV which were positive. Roche PCR viral loads were undetectable at baseline in each patient. Each patient was commenced on antiretroviral therapy in the second trimester: patient 1 on Combivir and Nevirapine (CD<sub>4</sub> 159) and patient 2 on Combivir and Ritonavir/Saquinavir (CD<sub>4</sub> 529). Vaginal deliveries were planned for each. Viral loads were retested at the GU reference laboratory and were found to be detectable at 716 in patient 1 using a primer targeting the conserved integrase region. This was subsequently used to adjudge viral suppression on ART.

A community midwife who was unaware of the HIV status of patient 2, repeated HIV testing. This reported the presence of HIV-2 antibodies only. Further inquiries showed that the initial HIV positive result had not been type specific and that the confirmatory test had not retyped the antibodies to HIV because patient 2 had been transferred from another UK centre as is routine practice locally. The presumption is made that full typing is performed at diagnosis.

**Conclusions:** The implications from these cases are significant. Acceptance that the viral load was undetectable may have missed otherwise detectable viraemia in patient 1 and missed appropriate management of HIV-2 in patient 2, with potential sequelae affecting MTCT.

### P75 ACICLOVIR DESENSITISATION IS A USEFUL TOOL FOR BOTH HIV POSITIVE AND NEGATIVE PATIENTS

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Patients often report allergic reactions to antibiotics. Given the multitude of agents available to treat most infections, an alternative therapy is usually available. Desensitisation may be indicated however, when therapeutic options are limited. We report on two recent cases involving successful aciclovir desensitisation that provided an invaluable tool to further management.

**Case 1:** A 29 year old HIV positive female developed bilateral acute retinal necrosis secondary to VZV. She had commenced HAART three months earlier but her CD4 count remained less than 100. After five days of intravenous acyclovir she developed a profuse erythematous skin

rash with lip swelling. Famciclovir produced a similar response and steroids and antihistamines made a slight, but unsustained improvement. Aciclovir desensitisation was performed, resulting in the patient being able to tolerate long term treatment with high dose oral aciclovir and possibly preventing complete loss of her vision.

**Case 2:** A 37 year old female presented to the genitourinary clinic in 2004 with her first episode of genital herpes. Unfortunately, the following day she developed chest pain and tongue swelling which was attributed to oral aciclovir and therefore, despite multiple recurrences of genital herpes was unable to receive suppressive therapy. The psychological effect of the recurrences was great and one year later she was desperate for help. Successful aciclovir desensitisation was performed allowing the patient to tolerate suppressive therapy and restore much of her lost confidence.

Both cases will be discussed further including details of the desensitisation regimen and discussion of the immunology of drug allergies.

### P76 ABORTED ABACAVIR HYPERSENSITIVITY IN A GENETICALLY SUSCEPTIBLE PATIENT

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**Introduction:** The true mechanism of abacavir hypersensitivity reaction (ABC HSR) is not fully understood but reported to be strongly associated with HLA-B\*5701 in whites. We report a case of possible aborted ABC HSR in a genetically susceptible patient.

**Case report:** A 30 year old white man was tested positive for HIV infection in 2000. He was started on didanosine, stavudine, and nevirapine. Viral load was <50 copies with this regimen, however this was changed to Combivir and nevirapine to prevent possible lipodystrophy. Patient complained of body fat changes and this was confirmed on examination. Possibility of changing the regimen and switching to Kivexa was discussed. This regimen was initiated on September 2005 while waiting for HLA-B\*5701 testing which was reported as positive on PCR-SS method. Patient presented 12 days after initiating the therapy with history of body rash, arthralgia and feeling hot. On examination a macular rash was found on the trunk and possibility of ABC HSR was suspected, and patient was advised to stop ABC. However patient decided to continue ABC under medical supervision. Symptoms improved after a week and he is still on this regimen to date.

**Discussion:** Previous study has reported prospective testing for and exclusion of HLA-B\*5701 has decreased the incidence of ABC HSR from 9% to 0%. However this is not yet a part of standard of care in UK due to lack of good evidence. Clinicians need to be aware of specificity of these tests and close monitoring of patients is essential.

### P77 CERVICAL SURVEILLANCE IN HIV+ WOMEN

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**Background:** The prevalence of CIN is up to 40% in HIV+ women. Low grade lesions rarely regress and high grade lesions may respond poorly to treatment. HAART may increase regression of low grade lesions. NHSCSP Guidelines (2004) recommend annual cytology and initial colposcopy on HIV diagnosis; lesions less severe than CIN II should probably not be treated.

**Methods:** The notes of 103 HIV+ women regularly attending our HIV outpatient clinic were retrospectively reviewed. Data including cytology history, colposcopy diagnoses, CD4+ level and use of HAART were collected.

**Results:** 23% of HIV+ patients had yearly smears, 61% had five-yearly smears, and 5% had never been screened. Only 9% patients had a colposcopy at initial HIV diagnosis. 31% patients had been referred to colposcopy with abnormal cytology, of these 69% attended a colposcopy appointment (n=22). Six patients were diagnosed with CIN III, nine patients with CIN II, and seven patients with CIN I. Mean CD4 level was inversely proportional to the degree of CIN. Data will be presented on the patients' management, CD4 levels, and the use of HAART in relation to regression of CIN and risk of residual CIN after treatment.

**Conclusion:** In this study a relationship between severity of immunosuppression and CIN grade was demonstrated. The effect of HAART on CIN needs to be evaluated further. Cervical screening and referral to colposcopy did not adhere to guidelines. Local protocols may improve performance. Should patients HIV and general hospital records be combined in the future there is potential to utilise the National Screening Programme for yearly recall.



# **P78 ARE WE "CYTOLOGICALLY ALERT" IN HIV INFECTION?**

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**Background:** As the evidence for the association between abnormal cervical cytology and HIV infection mounts, there is increasing responsibility on GUM Departments to ensure that cervical screening is adequate. In our Department, this is coordinated by a designated Health Advisor.

**Objectives:** To assess our adherence to UK screening guidelines, referral for colposcopy and subsequent follow up.

**Methods:** A retrospective case note review of 92/300 HIV infected women evaluated so far, seen between January 2000–December 2005.

**Results:** The majority of patients were of Black African origin 77/92 (83.7%). 47/92 (51%) between 25–34 years of age. Cytology was documented for 69/92 (75%). 38/69 (55%) had negative results at presentation: mean age 32.5 years, mean CD4 365; 12/38 were on HAART. 4/38 progressed to borderline change, one to moderate dyskaryosis and CIN2 on colposcopy over two years. Group A: 12/69 (17.4%) borderline: mean age 39.2 years, mean CD4 244; 7/12 were on HAART. 2/12 progressed to moderate dyskaryosis and CIN2 over two years. Group B: 12/69 (17.4%) mild dyskaryosis: mean age 35.2 years, mean CD4 343; 5/12 were on HAART. 1/12 progressed to moderate dyskaryosis and CIN3 and two progressed to severe dyskaryosis and CIN1 and CIN3 over one year. Group C: 4/69 (5.8%) moderate dyskaryosis: mean age 28 years, mean CD4 188; three were on HAART. Two had CIN2, one had CIN3, one defaulted colposcopy. Group D: 2/69 (2.9%) severe dyskaryosis: ages 45 and 37, CD4 40 and 350 respectively. The 45 year old was not on HAART and subsequently had a TAH for recurrent CIN3. 65/69 (94.2%) had screening within one year of HIV diagnosis.

**Conclusion:** HIV infected women in our Unit are being effectively managed and appropriately referred. This possibly by a Health Advisor led in-house call and recall system.

# **P79 A RETROSPECTIVE NOTES REVIEW TO DETERMINE WHETHER WOMEN AGED 20–24 YEARS WHO ATTEND A GENITOURINARY MEDICINE CLINIC ARE AT INCREASED RISK OF CERVICAL INTRAEPITHELIAL NEOPLASIA THAN THE GENERAL POPULATION**

J. L. Watson, S. M. Bates. *Department of GU Medicine, Royal Hallamshire Hospital, Sheffield, UK*

**Introduction:** The NHS cervical screening programme (NHSCSP) guidelines have recently changed excluding women under the age of 25. This change was based on screening studies in the general population.<sup>1</sup> Higher rates of cytological abnormalities have been reported among genitourinary medicine (GUM) attendees.<sup>2</sup> We report on the prevalence of cervical intraepithelial (CIN) in a GUM population of 20–24 year olds.

**Design:** A retrospective notes review of all women aged 20–24 returning a mild, moderate or severe dyskaryosis smear result between 1 June 2003 and 1 June 2004.

**Results:** 308 patients aged 20–24 had one or more smears within the defined time period. Thirty (9.7%) smears were reported as mild, three (1.0%) as moderate, and four (1.3%) as severe dyskaryosis. 19 (6.2%) patients were referred for colposcopy. 12 patients (3.9%) were diagnosed with CIN. Four (1.3%) reported CIN 1, one (0.3%) CIN 2, and seven (2.3%) CIN 3.

**Conclusions:** This study has shown a tenfold increase in CIN 3 in 20–24 year olds (2.3%) compared with the general population (0.24%).<sup>3</sup> Previous studies suggest cytological screening from the age of 20 provides adequate surveillance for women attending GU clinics, as CIN in teenagers rarely progresses to carcinoma in-situ prior to 21 years.<sup>4, 5</sup>

With the delay in onset of screening to 25 and high rates of CIN 3 in this population, the new guidelines may leave young women at risk of disease progression without discovery. Further research is required to determine whether GUM clinics should follow National Guidelines for screening in this age group.

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# **P80 IS GENITOURINARY MEDICINE BASED CERVICAL CYTOLOGY WORTHWHILE?**

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**Introduction:** The UK Cervical Screening Programme (introduced 1988) aimed to screen >80% of women 20–65 years old every 3–5 years. Opportunistic smears were discouraged. Women attending genitourinary medicine (GUM) clinics have higher prevalence of sexually transmitted infections including HPV with higher risk of cervical pathology. Some are not registered with a GP and less likely to access other cervical screening services.

**Methods:** We audited cervical cytology screening and outcome in a small District General GUM to review performance against National Guidelines and clinical outcomes.

**Results:** In 2004, of 105 performed (all adopting national guidelines) 63 (60%) were negative, 11 (10.5%) inadequate, and 31 (29.5%) abnormal. Seven of the inadequate cytologies were obscured by leucocytes (3 bacterial vaginosis, 2 Chlamydia). 21 needed six month repeat cytology: 10 of these had borderline changes (1 had moderate dyskaryosis at repeat), 10 had mild dyskaryosis (3 had mild dyskaryosis on repeat). 12 patients did not access repeat testing. 10 had results requiring referral for colposcopy: four moderate dyskaryosis (3 of which had CIN3) and six severe dyskaryosis (3 of whom had CIN3 at colposcopy). Results are compared to recent national statistics and discussed.

**Discussion:** (1) High rates of leucocyte obscured inadequate cytologies secondary to BV or Chlamydia support a policy to treat genital infection before performing cytology. (2) High rates of high grade abnormalities support continued cytology testing in GUM. (3) High levels of non-attendance for repeat cytology or colposcopy underlines importance of linking GUM samples to main screening programme.

# **P81 AUDIT OF COLPOSCOPY REFERRALS FROM A GU/STD CLINIC WITH REFERENCE TO AGE, HPV, AND CHLAMYDIA TRACHOMATIS**

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**Background:** Cervical cancer is increasing at 1.5%/year in Ireland with 50% mortality=2.2% of all cancer deaths. In Mid West pilot screening programme has begun to screen women 25–60. 66% of GU/STD clinic abnormal smears <25 years. Requests to abandon "opportunistic" screening prompted this audit.

Abstract P81

	Smear referral	%	Biopsy+	%	Biopsy+ <25	%<25	HPV	<25	%,<25	Both	<25	%,<25	CT	<25	%<25
CIN3	29	1%	22	0.8%	7	32%	10	2	45%	1	1	100%	5	4	80%
CIN2	69	3%	32	1.2%	13	41%	12	7	38%	1	0	0	0	0	0
CIN1	123	5%	39	1.5%	24	62%	29	17	74%				1	1	100%
NAD			56	3.5%	39	70%	24	20	43%	3	3	100%	1	1	100%
N/A			72	2.0%	34	47%	19	17	38%	11	7	64%	5	4	80%
Total	221	8%	149		117	53%	75	46	61%	5	4	80%	12	10	80%

Relative risk (RR) of referral to colposcopy with (1) HPV = 1.22 (2) chlamydia = 0.22, CIN2+CIN3 with (3) HPV = 1.09 (4) chlamydia = 0.75.

**Methods:** 221 patients referred to colposcopy over four years were audited. Retrospective analysis of GU/STD clinic files, hospital files and computer for biopsy reports. Ethical approval was obtained from "Drugs and Therapeutic Ethics Committee"

**Results:** 2637 smears were done from Nov 99–Sept 00.

**Findings:** See table.

**Discussion:** 221 (8%) of patients referred to colposcopy. 117 (53%) <25 years. RR of referral with chlamydia = 0.46 and HPV = 1.23. 33% CIN3 had chlamydia. 50% had HPV. Older women had higher grade changes.

**Conclusions:** 40% of proven high grade lesions were <25.

## **P82 TREATMENT OF HIGH GRADE ANAL INTRAEPITHELIAL NEOPLASIA AND ANAL WARTS**

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**Introduction:** Several studies have identified HPV related warts and anal intraepithelial neoplasia (AIN) in HIV positive and negative MSMs (men who have sex with men) as well as in other groups. Incidence of anal squamous carcinoma is recorded at 92 per 100 000 in HIV positive men on HAART, a considerably higher rate than in general population.

**Methods:** We looked at the treatment outcome of both anal warts and high grade AIN (AIN 2 and 3) in a high resolution anoscopy (HRA) clinic, over a seven year period.

**Results:** Of the 120 patients seen, 101 were men. 54 patients (45%) were HIV positive. 45 of 115 patients (39.1%) had high grade AIN (AIN 2/3). Overall, 63 of 99 patients were cleared of their disease at six month review. 24 patients (61.5%) with high grade disease remained clear at six months. Over a prolonged period of follow up, two out of the 24 patients developed recurrence.

**Conclusion:** Both anal warts and high grade AIN coexist in a number of patients. Both diseases are treatable with laser ablation and/or excision with HRA guidance. Further follow up data will be presented.

## **P83 INCIDENCE OF ANAL NEOPLASIA IN HIV POSITIVE WOMEN WITH MULTIFOCAL GENITAL NEOPLASIA**

M. Nathan, S. Longwill. Department of Sexual Health, Homerton University Hospital NHS Trust, London, UK

**Introduction:** Incidences of abnormal cervical smears and cervical neoplasia are increased amongst HIV positive women. Vulval intraepithelial neoplasia has also been noted with increased frequency in this population. Other reports identify the presence of anal disease through anal cytological surveillance.

**Methods:** Sixty eight HIV positive women were referred to colposcopy clinic with either abnormal cervical cytology or clinical cervical abnormalities. They were examined in a specialist colposcopy session and underwent a thorough examination of cervix, vagina, vulva, perineum, and anal canal. High resolution anoscopy (HRA) was carried out to detect anal disease in 38 cases. Data relating to their HIV disease were collected contemporaneously.

**Results:** Median age was 32 (range 24–56). x/68 patients were on antiretrovirals. 42 of the 68 women (62%) had abnormal cytology, while 15 (22%) had high grade cervical disease (CIN2 or 3). High grade neoplasia was identified in 30 of 68 women (44%). 13 women (19%) had disease involving three areas or more. Five women (7.3%) had negative smears but disease elsewhere. Of the 38 patients experiencing anoscopy, 12 (32%) had anal disease defined by histology. Women with anal disease had a mean CD4 count of 232, compared to 384 in women without anal disease ( $p < 0.05$ ).

**Conclusion:** Anal disease forms part of the spectrum of multifocal neoplasia in HIV positive women. High resolution anoscopy identifies anal disease in these patients and is recommended as part of their examination. Cytology alone is inadequate for detection of neoplasia in HIV positive women.

## **P84 DIAGNOSIS AND MANAGEMENT OF PENILE INTRAEPITHELIAL NEOPLASIA IN A SEXUAL HEALTH DEPARTMENT**

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Penile intraepithelial neoplasia (PIN) refers to clinically different conditions that share similar histological features of dysplasia. Although the natural history of PIN is not clear, early detection and

treatment will eliminate the disease and may prevent development of squamous cell carcinoma.

Since penile examination is routinely done in sexual health/genitourinary medicine (GUM) clinics, GUM physicians have the opportunity to diagnose PIN. A high index of suspicion and a low threshold for biopsy will aid early diagnosis. There are only few reports of PIN from GUM clinics and this may reflect underreporting or underdiagnosing.

We present seven cases of high grade PIN successfully managed in our department. The reasons for suspecting PIN and the clinical features seen will be discussed. "Penoscopy guided biopsy" of atypical areas seems to be the best way of diagnosing PIN. However, this may not always be practical. An alternative method is punch biopsy. Once a diagnosis of high grade neoplasia is made, it is important to consider early treatment. However, there is no standard treatment protocol for PIN. Several modalities of treatment have been described with varying success rates in specialties such as urology, dermatology and GUM. Follow up ranged from few months to two years.

We wish to share our experience of diagnosis and management of PIN. It is hoped that this paper will stimulate GUM physicians to make early diagnosis of PIN and facilitate appropriate management. Our experience suggests that laser ablation is highly successful.

penile intraepithelial neoplasia (PIN); laser treatment; sexual health department/GUM department

## **P85 EFFECTIVENESS OF DIFFERENT WART TREATMENTS IN A CLINICAL SETTING**

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Treatment of genital warts occupies much of GU Medicine clinic time. Modernisation requires looking for effective treatments with as few clinic visits as possible.

To assess the effectiveness of wart treatment in the clinic setting we performed a retrospective review of 526 women presenting with genital warts in 2002. There was a significant association between number of warts at presentation and age, younger women had more warts ( $p = 0.009$ ). There was a strong association with younger age and higher prevalence of STIs. Chlamydia was present in 29% of those under 20 years but only 1.5% of those 30+ ( $p < 0.0001$ ).

The number of warts at presentation was associated with number of attendances to clearance; fewer warts required fewer visits to clear. In women with >10 warts at presentation there was no significant difference in number of visits between first line treatment with cryotherapy, TCA, curettage, podophyllotoxin cream, or imiquimod cream. In women with <6 warts curettage required significantly fewer visits than cryotherapy, TCA, podophyllotoxin cream, or imiquimod cream.

Our clinic guidelines recommend imiquimod for multiple keratinised warts. Imiquimod was used in 89 patients who had significantly more warts and a higher rate of wart keratinisation. Consequently they required more visits to clearance, however they had a lower recurrence rate of 9% within one year compared with 17% in those who did not use imiquimod.

Curettage was a more effective treatment for women with <6 warts at presentation and the use of imiquimod resulted in fewer wart recurrences.

## **P86 PRIMARY PAGET'S DISEASE OF THE VULVA: TWO CASE REPORTS AND A REVIEW OF THE LITERATURE**

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A 68 year old lady was referred with a three month history of vulval pruritus which had not responded to topical steroids. Careful examination revealed a 3 cm slightly raised, rough, mildly erythematous area near the introitus. An immediate 3 mm punch biopsy showed localised Paget's disease with an immunophenotype suggestive of 1<sup>st</sup> disease. She was referred to gynaecology. Mammography, colonoscopy, cystoscopy, and a pelvic ultrasound were all normal. She is awaiting local excision.

Paget's disease of the vulva is an intraepithelial adenocarcinoma. 80% of cases are 1<sup>st</sup> and not associated with underlying neoplasia while ~20% of cases are associated with underlying neoplasia (2<sup>nd</sup>). The peak age incidence is 65. Vulval Paget's is rare representing 1–5% of all vulval malignancies. Pruritus is the commonest symptom present in ~70% of cases, while ~10% are asymptomatic.

Diagnosis is often delayed because changes may be subtle and pruritus is a common vulval complaint. This case illustrates the benefits of

careful examination to identify abnormal skin and the need for biopsy to make a definitive diagnosis. The immunophenotype is helpful in predicting primary or secondary disease. There is insufficient data to support using this alone to distinguish 1<sup>st</sup> and 2<sup>nd</sup> Page's. Patients should still be investigated to exclude underlying malignancy. The prognosis for localised 1<sup>st</sup> Page's is excellent although the five year recurrence rate is ~60%. With dermal invasion the prognosis is poor and with lymphatic involvement the five year survival rate is 0%.

### **P87 THE OUTPATIENT MANAGEMENT OF A BARTHOLIN'S ABSCESS: THE WORD CATHETER**

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**Objective:** To evaluate a conservative approach to Bartholin's abscess.  
**Design:** Non-randomised prospective interventional study.

**Setting:** Acute Gynaecology Unit (AGU) in an inner city London teaching hospital.

**Population:** Women diagnosed with a Bartholin's abscess.

**Methods:** Women diagnosed with a Bartholin's abscess were counselled about conventional surgical treatment (marsupialisation) or an alternative conservative approach—that is, insertion of a Word catheter. Women who opted for the Word catheter had it inserted in the AGU under local anaesthetic and were followed up at one week, before the catheter was removed at four weeks. The women recorded pain scores whilst the catheter was in situ and completed a qualitative questionnaire about their experience of the catheter after its removal. All women had telephone follow up at six months.

**Main Outcome Measure:** Resolution of the Bartholin's abscess.

**Results:** Fifty women attended the AGU with a Bartholin's abscess that required drainage, during the 12 month study period. 20/50 (40%) elected for surgery under general anaesthetic. 30/50 (60%) women elected to have a Word catheter inserted. 25/30 (83%) women had successful treatment of their abscess (three catheters fell out within 24 hours of insertion, one fell out after three days, and there was one failed insertion). No woman reported significant discomfort at one week. 23/25 women (92%) said that if they suffered a recurrent abscess, they would have another Word catheter inserted. 3/25 (12%) women had intercourse within the second week of catheter insertion and reported that it was not uncomfortable. One woman suffered a recurrence of the abscess after nine months and chose to have a second Word catheter inserted.

**Conclusions:** The Word catheter is a safe and effective treatment for a Bartholin's abscess. It should be offered to all women as an alternative to marsupialisation.

### **P88 STI/HIV PREVENTION IN CLINICAL SETTINGS: A WASTE OF TIME OR TIME WELL SPENT?**

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**Introduction:** Numerous STI/HIV prevention strategies are currently in use. Our aim was to develop both a consensus regarding their value and an evidence base for their delivery.

**Methods:** A literature review of the evidence base for nine prevention initiatives: contact tracing, condom availability, health promotion literature, emergency contraception, one-to-one health promotion, targeted interventions with reattenders, screening for STIs/HIV, hepatitis B immunisation, and post exposure prophylaxis for HIV after sexual exposure. Existing arrangements in local services were reviewed with site visits and discussions with key stakeholders.

**Results:** Sufficient evidence exists that partner notification is effective, especially provider referral. There is clear evidence that condoms prevent STI/HIV transmission and tentative evidence that providing free condoms increases condom carrying and use. There is sufficient evidence to support one-to-one counselling for HIV prevention, condom use, and preventing new STIs. Evidence exists that screening for chlamydia infection significantly reduces associated morbidity. The site visits highlighted that partner notification is more commonly used than provider notification. Generally very little work was undertaken with repeat attenders and lack of staff time was often seen as a constraint to undertaking effective interventions.

**Conclusion:** No single intervention is likely to be effective. It is worth developing partner notification to include methods such as "social network analysis", seeking out foci of infection within the community. The role of community health advisers could be enhanced and potential exists for developing targeted sessions for clinic re-attenders. There is

also scope for the greater involvement of community pharmacists in giving advice on sexual health.

### **P89 BLACK AFRICAN MEN AND WOMEN WITH HIV: ETHNICITY, PARTNERSHIPS, AND RISK**

J. Elford, J. Anderson<sup>1</sup>, F. Ibrahim, C. Bukutu. *City University London, <sup>1</sup>Homerton University Hospital*

**Objective:** To examine partnerships, ethnicity and sexual risk among black African men and women with diagnosed HIV.

**Methods:** The East London project is a confidential, questionnaire survey of patients diagnosed with HIV receiving treatment and care in outpatient clinics in North East London, 2004–05. Respondents were asked whether they were currently in a relationship, the HIV status and ethnicity of their current partner, and whether they had had unprotected sex with that partner in the previous three months.

**Results:** 1687 patients with HIV completed a self-administered questionnaire (response rate 73% of eligible patients) including 480 black African heterosexual women and 224 black African heterosexual men. Nearly two thirds of the women (62%) and three quarters of the men (72%) said they were currently in a relationship (married, cohabiting, or "living apart together"). The majority of those in a relationship (83% of women, 90% of men) said their partner was also black African of whom a substantial proportion (40–50%) were also HIV positive. Patients with an HIV positive partner were more likely to report unprotected sex with that partner than patients with a partner of unknown or discordant HIV status (women, 32% v 15%,  $p=0.001$ ).

**Conclusion:** The majority of black African men and women with diagnosed HIV who were in a relationship said their partner was also black African; a substantial number of their partners were also HIV positive. For black African men and women with diagnosed HIV, ethnicity as well as HIV status are important determinants of sexual partnership and risk.

### **P90 HIV INFECTION AND PARTNER NOTIFICATION: WHAT IS ACHIEVABLE?**

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**Aim:** A review of 200 cases of HIV infection presenting in our department from 2001 to 2005.

**Method:** Retrospective case note review was undertaken. Details of following were noted: demographic details, possible mode of acquisition, co-infection including STIs, degree of immune suppression at presentation, treatment status, outcome of partner notification, background, and awareness of partner's status, etc.

**Results:** Details of 95 case notes completed so far. Majority (93% (89/95)) of the infection was acquired heterosexually and mostly (63% (63/95)) were female of Black African (85% (81/95)) Sub-Saharan (82% (67/81)) origin. Commonest (50% (48/95)) age group was 30–39 years. 46% (44/95) were in employment and 44% (42/95) showed the presence of other STIs and 32% (31/95) had either Hep B/HepC co-infection. Partner notification was possible in 93% (89/95) cases and further screening and testing of their contacts undertaken in 44% (42/95). 54% (52/95) of their partners were aware of index case's HIV status. Large majority (63% (60/95)) of our patients had one sexual contact in last one year. 28% (27/95) our patients had HIV +ve partners. 65% (62/95) patients had CD4 counts >200 and 16% (16/95) patients were on HAART during their diagnosis.

**Conclusion:** In the absence of any recommended standard and without help of any additional increase in resources the rate (93%) of our partner notification in a diverse and mobile patient population was commendable. The practise of seeing the couples together after the testing will further facilitate the process.

### **P91 THE ROLE OF THE HEALTH ADVISER IN HIV RELATED PARTNER NOTIFICATION: A MISSED OPPORTUNITY**

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**Background:** Systematic approaches to partner notification (PN) in HIV infection are rare in UK practice. National outcome standards and best practice guidelines are yet to be developed. As part of HIV care pathway development in a large provincial GUM clinic, the role of Health advisers (HA) in health education and contact tracing of newly diagnosed HIV positive patients was reviewed. An audit tool was developed to evaluate practice.



**Methods:** Retrospective case note audit of new patients attending between 1/9/03 and 31/5/2004 with an HIV diagnosis. Audit criteria for STI screening, documented health education advice and PN activity were developed comparable to other STIs. Target time for contact attendance was set to within 12 months of index diagnosis.

**Results:** Sixty five patients (40 female, 4 MSM) were seen.

**Conclusions:** The audit tool has revealed significant differences in partner disclosure, attendance and testing when health advisers were involved with newly diagnosed HIV patients. Many of those not seen by HAs were transfers from other services. A change in practice to enhance HA involvement at HIV diagnosis of all new patients has been implemented. A re-audit is in progress.

#### Abstract P91

	Saw HA	Not seen HA	Total
Index patients	28	37	65
Regular partners disclosed	23	21	44
Partners attending within 1 year	13	4	17
Partners tested	9	4	13
Contact tracing ratio (contacts attending per index)	0.46*	0.10*	0.26

$p < 0.001$ , OR 7.15 (CI 1.75–31.65) RR 2.45 (1.49–4.02).

#### P92 SAFER SEX TEXT MESSAGES: EVALUATING A HEALTH EDUCATION INTERVENTION IN AN ADOLESCENT POPULATION

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**Background:** In response to an increasing number of adolescents presenting with STIs it was decided to look at an innovative intervention to try and improve condom usage.

**Methods:** A total of 60 people attending the young persons clinic, aged 17 and 18 years of age were invited to take part in this randomised controlled study. Thirty participants received weekly text messages for three months. The other 30 participants were the control group. The text messages, for example "avoid infection, use protection. Use a condom", were made up by the authors and a different message was sent out each week. At the end of the three month period all 60 participants were contacted to complete a structured telephone interview to ascertain their "risk" behaviour during this period.

**Results:** Total response rate to telephone interview 48% of whom 55% received texts (see table). 87.5% found the text messages useful in their decision making to use condoms. The safer sex messages were rated as Excellent (19%) Very good (37%) Good (37.5%). 12.5% did not respond. Texts were forwarded to friends by 19% of the cohort. Overall while there was a positive response to text messages it was interesting to note that participants in the control group stated the clinic visit had impacted on their sexual behaviour.

#### Abstract P92

Safer sex text messages	Experimental group	Control group
Diagnosed with STI at initial visit	45% (6)	54% (15)
Change of partner since clinic visit	56% (9)	15% (2)
Hx UPSI since clinic visit	31% (5)	15% (2)

#### P93 MEDIA CAMPAIGNS FOR SEXUAL HEALTH: AN EXPLORATION OF THEIR POTENTIAL IMPACT ON YOUNG PEOPLE'S ATTITUDES TO SEXUAL HEALTH AND SEXUAL HEALTH SEEKING BEHAVIOUR

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**Background:** In Spring 2006 the Department of Health is due to launch a high profile sexual health campaign targeted at 16–34 year olds. We conducted a study to assess the potential impact of two hypothetical

sexual health messages on young persons' attitudes, and sexual health-seeking behaviours. The first message addressed high rates of chlamydia infection, and recommended testing. The second message advised wearing a condom, as both sexually transmitted infections (STIs) and HIV were increasing.

**Methods:** Questionnaires were distributed to 160 consecutive patients <18 years attending two young people's sexual health clinics in a community and hospital setting. Questionnaires were self-completed and data were analysed using SPSS. Demographic data were compared with responses to the two hypothetical sexual health messages.

**Results:** 102/160 questionnaires were obtained. Only 56% (57/102) of respondents were aware of any existing sexual health campaigns. 90% (92/102) felt the chlamydia message would make them more likely to visit a sexual health clinic, with the same proportion indicating it would make them more likely to visit with a new partner. 87% (89/102) felt the condom message would make them more likely to visit a sexual health clinic. A higher proportion, 93% (95/102), indicated the condom message would make them more likely to visit with a new partner.

**Conclusions:** Young people's awareness of existing sexual health campaigns is poor. Sexual health campaigns may promote increased attendance at GU medicine clinics. Clinics need to urgently address capacity issues, in anticipation of potentially increased demand for services.

#### P94 LEVEL OF REPORTED AWARENESS OF PARTNER'S CONTRACEPTION IN ADOLESCENT MEN ATTENDING AN URBAN GENITOURINARY MEDICINE CLINIC

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**Methods:** This was a retrospective case note. The data were gathered from a proforma routinely used.

**Results:** 276 male patients aged 15–20 year old attended the clinic. The major ethnic groups were black Caribbean, white British, and black African. One hundred and sixty (59%) of the patients had more than two sexual partners in three months (2.20 (SD 1.98), range 2–15). No association existed between number of partners and ethnic origin. There was an inverse relationship between awareness of partner's contraception and number of partners. 79% of those with one partner knew their partner's contraception, but of those with two or more partners only 54% were aware for both regular and casual female partners. Of the latter, 28 (43%) knew only about their regular female partner's contraception while 37 (57%) did not know for both regular and casual partners. Of those patients aware of their partners contraception (n=152), 73 (48%) relied upon their female partners for contraception but not for STI prevention. Of those patients in single-partner relationships (n=95), 19 (20%) used consistently condom for contraception, 35 (37%) relied upon their female partners for contraception but not for STI prevention, and 41 (43%) did not use condoms at all.

**Conclusions:** (1) There was inconsistent use of barrier methods. (2) With an increase in sexual partners came a reduction in the knowledge of female contraception. (3) A positive association between condom use and awareness of female contraceptive method (the males who used less consistently a condom) were also less aware of partner's contraception.

#### P95 CLINICAL NETWORKS: THEIR IMPORTANCE AND POTENTIAL FOR DEVELOPING NURSES WORKING IN SEXUAL HEALTH

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**Introduction:** Nurses working within genitourinary medicine (GUM) services or primary care have important roles if government sexual health targets are to be achieved. To increase nurses' roles in service delivery, investment in terms of education and the development of clinical skills is required. These need to be supported by robust packages of Clinical Guidelines, Integrated Care Pathways, and Patient Group Directions (PGDs). Many smaller services do not have the infrastructure to support such developments which is why creation of Sexual Health Clinical Networks as advocated in the National Strategy for Sexual Health and HIV is important.

**Method:** Following creation of the North East London Sexual Health Network (NELNET), a survey of sexual health nurses in both genitourinary and contraceptive services in NE London was undertaken in 2005 to identify the educational/development needs of nurses across different services within the network.

**Findings:** Data demonstrated wide variance in roles and responsibilities with significant commonality in educational/development needs sug-

gesting joined up nursing development across primary/secondary care, resulting in more nurses with interchangeable GU/contraceptive skills is required.

**Action taken:** The NE London Sexual Health Nurses' Forum (NELSHNF) supported by NELNET was formed to provide a mechanism to support the widespread development of sexual health nurses by facilitating the:

- standardisation of nursing documentation
- provision of network training to support the use of these
- coordinated nursing research and audit activities.

During 2005/06 NELSHNF implemented a programme of clinical skills training for nurses across NE London. Programmes completed include PGDs and darkfield microscopy training.

#### **P96 THE FIRST FOUR YEARS OF A UK WIDE MULTIDISCIPLINARY FOUNDATION COURSE ON SEXUALLY TRANSMITTED INFECTIONS**

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A cornerstone of the National Sexual Health and HIV strategy for England & Wales (2000) was the recommendation for increased primary care involvement in the delivery of sexual health services. Surveys have shown that undergraduate and postgraduate teaching in STIs varies greatly in the UK, and in places is virtually non-existent. To address this, the concept of a course, developed and administered centrally by the BASHH but delivered locally, was adopted using the model of the Resuscitation Council of England. Using modern adult education theory, core learning objectives were developed for participant knowledge, skills, and attitudes. These were set at a foundation level for adult learners and a competency-based curriculum was developed. It was recognised that confidence in taking a sexual history underpins the ability to manage all sexual health problems. The BASHH national guidelines for the management of STIs were used as the basis for the factual course content.

Specialists have enthusiastically delivered the course: by the end of 2005, 75 centres had held 210 courses, with 9020 delegates from a broad spectrum of health settings, primarily general practice. Evaluation is consistently excellent.

We need to know whether attendance leads to a change in clinical practice and if, in turn, this improves sexual health outcomes. A needs assessment conducted among GPs in one region shows that the course meets those needs very well. Family planning staff who attended a Glasgow course demonstrated improvement in knowledge and skills following the course and a follow up among GPs after a STIF course in Brighton found a significant increase in chlamydia testing that was sustained at six months.

#### **P97 HOW TO IMPROVE THE UNDERGRADUATE LEARNING AND TEACHING EXPERIENCE IN SEXUAL HEALTH IN ONLY FOUR DAYS**

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**Introduction:** Teaching fatigue was setting in badly as we delivered the same Sexual Health programme every two weeks of Year 4 to undergraduates at GKT Medical School. Extensive curriculum revision afforded the opportunity to rethink. Our programme was restructured, piloted and evaluated in September 2005. BASHH Undergraduate Teaching Guidelines (2005) informed objectives and content.

**Outcome:** Teaching is now delivered in 3.5 days of interactive sessions early each term. History taking skills are prioritised and practised and a new Ethics section has been introduced by student request.

#### **Abstract P97 Year 4 teaching timetable in sexual health**

Day	Topic
MONDAY	Introduction to Sexual Health Services Epidemiology of STIs and HIV Sexual History Taking: How to ask, what to ask Workshop, video, role plays
TUESDAY	Genital Ulcers, Lumps Male Dysuria, Discharge Health Advisers' Session Sexual History Workshop, role plays Focus on HIV
WEDNESDAY morning	Vaginal Discharge Pelvic Pain, PID Sexual Dysfunction Rape, Sexual Assault
THURSDAY	HIV Natural History, Classification Opportunistic Infections Ethical Issues, HIV, Sexual Health Debates HIV care Non Medical Needs Therapeutics Case Histories Questions, Answers Course Evaluation

Students sign up on the virtual campus for 2 GUM and 1 HIV clinics (0.5 day) during the rest of term. The course was well evaluated by students, teachers, and the Educationalist. Scores and comments will be presented.

**Discussion:** We believe we have maximised the short time available to improve the learning and teaching experience in Sexual Health. We present this to help other Departments who, like us, constantly strive to balance Educational and Service needs.